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**Mary Fallin, Governor**
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**Secretary of State**
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| **LIEUTENANT** Governor | 410 |
| Oklahoma **LINKED** Deposit Review Board | 415 |
| Oklahoma **LIQUEFIED** Petroleum Gas Board | 420 |
| Oklahoma **LIQUEFIED** Petroleum Gas Research, Marketing and Safety Commission | 422 |
| **LITERACY** Initiatives Commission | 425 |
| **LONG-RANGE** Capital Planning Commission | 428 |
| Oklahoma State Board of Examiners for **LONG-TERM** Care Administrators (*Formerly:* Oklahoma State Board of Examiners for **NURSING** Home Administrators) - *See* Title 490 | |
| **LOTTERY** Commission, Oklahoma | 429 |
| Board of Trustees for the **MCCURTAIN** County Higher Education Program *(exempted 11-1-98)* | 430 |
| Commission on **MARGINALLY** Producing Oil and Gas Wells | 432 |
| State Board of **MEDICAL** Licensure and Supervision | 435 |
| **MEDICAL** Technology and Research Authority of Oklahoma | 440 |
| Board of **MEDICOLEGAL** Investigations | 445 |
| Department of **MENTAL** Health and Substance Abuse Services | 450 |
| **MERIT** Protection Commission | 455 |
| **MILITARY** Planning Commission, Oklahoma Strategic | 457 |
| Department of **MINES** | 460 |
| Oklahoma **MOTOR** Vehicle Commission | 465 |
| Board of Regents of **MURRAY** State College *(exempted 11-1-98)* | 470 |
| Oklahoma State Bureau of **NARCOTICS** and Dangerous Drugs Control | 475 |
| Board of Regents of **NORTHERN** Oklahoma College *(exempted 11-1-98)* | 480 |
| Oklahoma Board of **NURSING** | 485 |
| Oklahoma State Board of Examiners for **LONG-TERM** Care Administrators (*Formerly:* Oklahoma State Board of Examiners for **NURSING** Home Administrators) | 490 |
| Board of Regents of **OKLAHOMA** City Community College *(exempted 11-1-98)* | 495 |
| Board of Regents of **OKLAHOMA** Colleges *(exempted 11-1-98)* | 500 |
| Board of Examiners in **OPTOMETRY** | 505 |
| State Board of **OSTEOPATHIC** Examiners | 510 |
| **PARDON** and Parole Board | 515 |
| Oklahoma **PEANUT** Commission | 520 |
| Oklahoma State **PENSION** Commission | 525 |
| State Board of Examiners of **PERFUSIONISTS** | 527 |
| Office of **PERSONNEL** Management | 530 |
| Board of Commercial **PET** Breeders | 532 |
| Oklahoma State Board of **PHARMACY** | 535 |
| **PHYSICIAN** Manpower Training Commission | 540 |
| Board of **PODIATRIC** Medical Examiners | 545 |
| Oklahoma **POLICE** Pension and Retirement System | 550 |
| State Department of **POLLUTION** Control *(abolished 1-1-93)* | 555 |
| **POLYGRAPH** Examiners Board | 560 |
| Oklahoma Board of **PRIVATE** Vocational Schools | 565 |
| State Board for **PROPERTY** and Casualty Rates *(abolished 7-1-06; see also Title 365)* | 570 |
| State Board of Examiners of **PSYCHOLOGISTS** | 575 |
| Department of **CENTRAL** Services (*Formerly*: Office of **PUBLIC** Affairs) | 580 |
| **PUBLIC** Employees Relations Board | 585 |
| Oklahoma **PUBLIC** Employees Retirement System | 590 |
| Department of **PUBLIC** Safety | 595 |
| **REAL** Estate Appraiser Board | 600 |
| Oklahoma **REAL** Estate Commission | 605 |
| Board of Regents of **REDLANDS** Community College *(exempted 11-1-98)* | 607 |
| State **REGENTS** for Higher Education | 610 |
| State Department of **REHABILITATION** Services | 612 |
| Board of Regents of **ROGERS** State College *(exempted 11-1-98)* | 615 |
| Board of Regents of **ROSE** State College *(exempted 11-1-98)* | 620 |
| Oklahoma **SAVINGS** and Loan Board *(abolished 7-1-93)* | 625 |
| **SCENIC** Rivers Commission | 630 |
| Oklahoma Commission on **SCHOOL** and County Funds Management | 635 |
| Advisory Task Force on the Sale of **SCHOOL** Lands *(functions concluded 2-92)* | 640 |
| The Oklahoma School of **SCIENCE** and Mathematics | 645 |
| Oklahoma Center for the Advancement of **SCIENCE** and Technology | 650 |
| **SECRETARY** of State | 655 |
| Department of **SECURITIES** | 660 |
| Board of Regents of **SEMINOLE** State College *(exempted 11-1-98)* | 665 |
| **SHEEP** and Wool Commission | 670 |
| State Board of Licensed **SOCIAL** Workers | 675 |
| **SOUTHERN** Growth Policies Board | 680 |
| Oklahoma **SOYBEAN** Commission *(abolished 7-1-97)* | 685 |
| Board of Examiners for **SPEECH-LANGUAGE** Pathology and Audiology (*Formerly:* Board of Examiners for **SPEECH** Pathology and Audiology) | 690 |
| **STATE** Employee Charitable Contributions, Oversight Committee for (*Formerly*: **STATE** Agency Review Committee) | 695 |
| **STATE** Use Committee (*Formerly:* Committee on Purchases of Products and Services of the Severely **HANDICAPPED**) –*See* Title 304 | |
| Oklahoma **STUDENT** Loan Authority | 700 |
| **TASK** Force 2000 | 705 |
| Oklahoma **TAX** Commission | 710 |
| Oklahoma Commission for **TEACHER** Preparation | 712 |
| **TEACHERS'** Retirement System | 715 |
| State **TEXTBOOK** Committee | 720 |
| **TOBACCO** Settlement Endowment Trust Fund | 723 |
| Oklahoma **TOURISM** and Recreation Department | 725 |
| Department of **TRANSPORTATION** | 730 |
| Oklahoma **TRANSPORTATION** Authority (*Name changed to* Oklahoma **TURNPIKE** Authority *11-1-05*) - *See* Title 731 | |
| Oklahoma **TURNPIKE** Authority (*Formerly:* Oklahoma **TRANSPORTATION** Authority AND Oklahoma **TURNPIKE** Authority) - *See* also Title 745 | 731 |
| State **TREASURER** | 735 |
| Board of Regents of **TULSA** Community College *(exempted 11-1-98)* | 740 |
| Oklahoma **TURNPIKE** Authority (*Name changed to* Oklahoma **TRANSPORATION** Authority *11-1-99 - no rules enacted in this Title - See* Title 731) | 745 |
| Oklahoma **UNIFORM** Building Code Commission | 748 |
| Board of Trustees for the **UNIVERSITY** Center at Tulsa *(exempted 11-1-98)* | 750 |
| **UNIVERSITY** Hospitals Authority | 752 |
| **UNIVERSITY** Hospitals Trust | 753 |
| Board of Regents of the **UNIVERSITY** of Oklahoma *(exempted 11-1-98)* | 755 |
| Board of Regents of the **UNIVERSITY** of Science and Arts of Oklahoma *(exempted 11-1-98)* | 760 |
| Oklahoma **USED** Motor Vehicle and Parts Commission | 765 |
| Oklahoma Department of **VETERANS** Affairs | 770 |
| Board of **VETERINARY** Medical Examiners | 775 |
| Oklahoma Department of **CAREER** and Technology Education (*Formerly:* Oklahoma Department of **VOCATIONAL** and Technical Education) | 780 |
| Oklahoma **WATER** Resources Board | 785 |
| Board of Regents of **WESTERN** Oklahoma State College *(exempted 11-1-98)* | 790 |
| Oklahoma **WHEAT** Commission | 795 |
| Department of **WILDLIFE** Conservation | 800 |
| **WILL** Rogers and J.M. Davis Memorials Commission | 805 |

# 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 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
## CHAPTER 100. AIR POLLUTION CONTROL

*[OAR Docket #13-775]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 7. Permits for Minor Facilities
Part 9. Permits-by-Rule
252:100-7-60. [AMENDED]
252:100-7-60.5. [NEW]
Appendix E. Primary Ambient Air Quality Standards [REVOKED]
Appendix E. Primary Ambient Air Quality Standards [NEW]

**SUMMARY:**

The Department is proposing to modify OAC 252:100-7, Permits for Minor Facilities, to add a new Permit By Rule (PBR) for minor facilities and area sources in the oil and natural gas (O&NG) sector. The PBR would streamline the permitting process for O&NG sources affected by recent changes to the federal standards. The Department is also proposing to update the PBR general requirements and references. The Department is proposing to change the requirements regarding registration under PBRs to make the registration effective upon receipt of the application by the Department of Environmental Quality.

The Department proposes changing Appendix E, Primary Ambient Air Quality Standards, to maintain consistency with the National Ambient Air Quality Standards. Specifically, the primary standards for particulate matter less than or equal to 2.5 microns in diameter ($PM_{2.5}$) would be modified to reflect recent changes made by the Environmental Protection Agency.

**AUTHORITY:**

The powers and duties of the Environmental Quality Board are set out in 27A O.S. Section 2-2-101 and 27A O.S. Section 2-5-106 and those of the Air Quality Advisory Council in 27A O.S. Section 2-2-201 and 27A O.S. Section 2-5-107. The legal authority authorizing the proposed rules is found in the Oklahoma Clean Air Act, 27A O.S. Sections 2-5-101 through - 117, specifically 27A O.S. Section 2-5-105 for Subchapter 7 and Appendix E; and 27A O.S. Section 2-5-112 and -114 for Subchapter 7.

**COMMENT PERIOD:**

Comments were accepted from March 15, 2013 through April 17, 2013. The comment period was completed pursuant to the Notice of Rulemaking Intent published at 30 Ok Reg 377.

**PUBLIC HEARINGS:**

A public hearing will be held before the Environmental Quality Board at 9:30 a.m. on Tuesday, August 20, 2013, at the Tri County Technology Center, 6101 SE Nowata Road, Bartlesville, Oklahoma 74006.

**REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

**COPIES OF PROPOSED RULES:**

The proposed rules are available for review on the DEQ Air Quality Division website at http://www.deq.state.ok.us/AQDnew/council_mtgs/index.htm. Copies also may be obtained from the Department by calling the contact person listed below.

**RULE IMPACT STATEMENT:**

The rule impact statement is available for review on the DEQ Air Quality Division website at http://www.deq.state.ok.us/AQDnew/council_mtgs/index.htm. Copies also may be obtained from the Department by calling the contact person listed below.

**CONTACT PERSON:**

The contact person for this proposal is Cheryl E. Bradley, Environmental Programs Manager, at (405) 702-4100, or cheryl.bradley@deq.ok.gov. Mail should be addressed to Department of Environmental Quality, Air Quality Division, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, ATTN: Cheryl E. Bradley. The Air Quality Division FAX number is (405)702-4101.

**ADDITIONAL INFORMATION:**

This Notice reflects a date and location change for the hearing of these rules by the Environmental Quality Board.

**PERSONS WITH DISABILITIES:**

Should you desire to attend but have a disability and need an accommodation, please notify the Air Quality Division three (3) days in advance at (405)702-7100. For the hearing impaired, the TDD relay number is 1-800-522-8506 or 1-800-722-0353, for TDD machine use only.

*[OAR Docket #13-775; filed 5-16-13]*

## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
## CHAPTER 100. AIR POLLUTION CONTROL

*[OAR Docket #13-776]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 5. Registration, Emission Inventory and Annual Operating Fees
252:100-5-2. [AMENDED]
252:100-5-2.1 [AMENDED]
252:100-5-3. [AMENDED]
Subchapter 17. Incinerators
Part 3. General Purpose Incinerators
252:100-17-2. [AMENDED]
Part 9. Commercial and Industrial Solid Waste Incineration Units
252:100-17-60. [AMENDED]
252:100-17-61. [AMENDED]
252:100-17-62. [AMENDED]
252:100-17-63. [AMENDED]
252:100-17-64. [AMENDED]
252:100-17-65. [AMENDED]
252:100-17-66. [AMENDED]
252:100-17-67. [AMENDED]
252:100-17-68. [AMENDED]
252:100-17-69. [AMENDED]
252:100-17-70. [AMENDED]
252:100-17-71. [AMENDED]
252:100-17-72. [AMENDED]
252:100-17-73. [AMENDED]
252:100-17-74. [AMENDED]
252:100-17-75. [AMENDED]
252:100-17-76. [AMENDED]

**SUMMARY:**

The Department is proposing to modify Subchapter 5, Registration, Emission Inventory and Annual Operating Fees to amend the current emission inventory reporting schedule in OAC 252:100-5-2.1 for all minor source facilities registered under a Permit by Rule (PBR). The current rule requires PBR facilities with emissions greater than 5 tons per year to file an emission inventory every year and PBR facilities with emissions less than 5 tons per year to file an emission inventory every five years. Under the proposed rule, PBR facilities would be required, at a minimum, to submit an annual emission inventory for the first calendar year in which the facility is registered. Thereafter, the proposed new schedule would require all PBR facilities with actual emissions greater than 5 tons per year to file an emission inventory every three years, and would require PBR facilities with actual emissions of 5 tons or less per year to file an emission inventory every six years, coinciding with the National Emissions Inventory. Additionally, the Department proposes to modify language in 252:100-5-2, -2.1, and -3 to make a correction and to remove obsolete language. This proposal does not include any changes to annual operating fees.

The Department is proposing to modify OAC 252:100-17, Part 3, General Purpose Incinerators and Part 9, Commercial and Industrial Solid Waste Incineration Units (CISWI), to adjust enforceable requirements and compliance dates consistent with federal requirements that were revised February 7, 2013. The proposal incorporates changes required as a result of revisions to 40 CFR 60, Subpart DDDD for state plans under Sections 111(d) and 129 of the federal Clean Air Act (CAA), applicable to existing CISWI units. The proposed changes to Subchapter 17 will be included as a required update to Oklahoma's Section 111(d)/129 plan. These changes affect which CISWI units are treated as existing CISWI units.

**AUTHORITY:**

The powers and duties of the Environmental Quality Board are set out in 27A O.S. Section 2-2-101 and 27A O.S. Section 2-5-106 and those of the Air Quality Advisory Council in 27A O.S. Section 2-2-201 and 27A O.S. Section 2-5-107. The legal authority authorizing the proposed rules is found in the Oklahoma Clean Air Act, 27A O.S. Sections 2-5-101 through - 117, specifically 27A O.S. Section 2-5-105 for Subchapters 5 and 17 and 27A O.S. Section 2-5-112 for Subchapter 5.

**COMMENT PERIOD:**

Written comments on the proposed rulemakings will be accepted prior to and at the hearing on July 17, 2013. For comments received at least five (5) business days prior to the Council meeting, staff will post written responses on the Department's web page at least one (1) day prior to the Council meeting. Oral comments may be made at the July 17, 2013 hearing and at the August 20, 2013 Environmental Quality Board hearing.

**PUBLIC HEARINGS:**

A public hearing is scheduled before the Air Quality Advisory Council at 9:00 a.m. on Wednesday, July 17, 2013, at the DEQ headquarters, 707 N. Robinson, Oklahoma City, Oklahoma 73102.

If the Council recommends adoption of the proposed rules, an additional public hearing will be held before the Environmental Quality Board at its next meeting, currently scheduled for 9:30 a.m. on Tuesday, August 20, 2013, at the Tri County Technology Center, 6101 SE Nowata Road, Bartlesville, Oklahoma 74006.

These hearings shall also serve as public hearings to receive comments on the proposed revisions to the State Implementation Plan (SIP) under the requirements of 40 CFR Section 51.102 and 27A O.S. Section 2-5-107; to the CISWI State Plan under the requirements of the CAA, Sections 111(d) and 129, 40 CFR Part 60, Subparts B and DDDD, and 27A O.S. Section 2-5-107; and to the State Title V (Part 70) Implementation Plan under the requirements of 40 CFR Part 70 and 27A O.S. Section 2-5-112.

**REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

The Department requests that business entities or any other members of the public affected by these rules provide the

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

**COPIES OF PROPOSED RULES:**

The proposed rules are available for review 30 days prior to the hearing on the DEQ Air Quality Division website at http://www.deq.state.ok.us/AQDnew/council_mtgs/index.htm. Copies also may be obtained from the Department by calling the contact person listed below.

**RULE IMPACT STATEMENTS:**

The rule impact statements will be available on and after June 17, 2013 on the DEQ Air Quality Division website at http://www.deq.state.ok.us/AQDnew/council_mtgs/index.htm. Copies also may be obtained from the Department by calling the contact person listed below.

**CONTACT PERSON:**

The contact person for these proposals is Cheryl E. Bradley, Environmental Programs Manager, at (405) 702-4218. Please send written comments on the proposed rule changes to Ms. Bradley at cheryl.bradley@deq.ok.gov. Mail should be addressed to Department of Environmental Quality, Air Quality Division, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, ATTN: Cheryl E. Bradley. The Air Quality Division FAX number is (405)702-4101.

**PERSONS WITH DISABILITIES:**

Should you desire to attend the public hearing but have a disability and need an accommodation, please notify the Air Quality Division three (3) days in advance at (405)702-4172. For the hearing impaired, the TDD relay number is 1-800-522-8506 or 1-800-722-0353, for TDD machine use only.

*[OAR Docket #13-776; filed 5-16-13]*

# Cancelled Hearings/Comment Periods

If an agency cancels a hearing or comment period announced in a published Notice of Rulemaking Intent, the agency must submit a notice of such cancellation to the Office of Administrative Rules (OAR). The OAR publishes the cancellation notice in the next possible issue of the *Register.*

*For additional information on cancelled hearings and comment periods, see OAC 655:10-7-27.*

## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
## CHAPTER 100. AIR POLLUTION CONTROL

*[OAR Docket #13-774]*

**RULEMAKING ACTION:**

Cancelled Public Hearing relating to a proposed PERMANENT rulemaking action

**PROPOSED RULES:**

Subchapter 7. Permits for Minor Facilities
Part 9. Permits-by-rule
252:100-7-60. [AMENDED]
252:100-7-60.5. [NEW]
Appendix E. Primary Ambient Air Quality Standards [REVOKED]
Appendix E. Primary Ambient Air Quality Standards [NEW]

**REGISTER PUBLICATION OF NOTICE:**

The Notice of Rulemaking Intent for this action was published in the Oklahoma Register, Volume 30, Number 13, March 15, 2013.

**CANCELLED PUBLIC HEARING:**

Before the Environmental Quality Board at 9:30 a.m. on Tuesday, June 18, 2013, at the Great Plains Area Vo-Tech, 2001 E. Gladstone, Frederick, Oklahoma 73542.

*[OAR Docket #13-774; filed 5-16-13]*

# 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 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION CHAPTER 10. PHYSICIANS AND SURGEONS

*[OAR Docket #13-868]*

**RULEMAKING ACTION:**
Submission for gubernatorial and legislative review
**RULES:**
Subchapter 4. Application and Examination Procedures for Licensure as Physician and Surgeon
435:10-4-6. Medical licensure examination [AMENDED]
**SUBMITTED TO GOVERNOR:**
May 17, 2013
**SUBMITTED TO HOUSE:**
May 17. 2013
**SUBMITTED TO SENATE:**
May 17, 2013

*[OAR Docket #13-868; filed 5-21-13]*

## TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION CHAPTER 10. PHYSICIANS AND SURGEONS

*[OAR Docket #13-869]*

**RULEMAKING ACTION:**
Submission for gubernatorial and legislative review
**RULES:**
Subchapter 1. General Provisions
435:10-1-4. Definitions [AMENDED]
**SUBMITTED TO GOVERNOR:**
May 17, 2013
**SUBMITTED TO HOUSE:**
May 17. 2013
**SUBMITTED TO SENATE:**
May 17, 2013

*[OAR Docket #13-869; filed 5-21-13]*

# 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 260. ~~OFFICE OF STATE FINANCE~~OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
## CHAPTER 1. ADMINISTRATIVE OPERATIONS

*[OAR Docket #13-922]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 1. Administrative Operations
260:1-1-1. Purpose [AMENDED]
260:1-1-2. Chief administrative officer [AMENDED]
260:1-1-3. Availability of records [AMENDED]
260:1-1-4. Organization of the ~~Office of State Finance~~Office of Management and Enterprise Services [AMENDED]
260:1-1-5. Appeals [AMENDED]
**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-922; filed 5-24-13]*

## TITLE 260. ~~OFFICE OF STATE FINANCE~~OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
## CHAPTER 10. PROMPT PAYMENT TO VENDORS AND EMPLOYEES OF THE STATE OF OKLAHOMA THROUGH THE PAYMENT OF INTEREST ON LATE PAYMENTS

*[OAR Docket #13-923]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 1. General Provisions
260:10-1-1. Purpose [AMENDED]
260:10-1-2. Definitions [AMENDED]
260:10-1-3. Scope [AMENDED]
Subchapter 3. Vendor and Employee Interest Claim Procedures
260:10-3-1. Agency Payments [AMENDED]
260:10-3-3. Calculation of interest [AMENDED]
260:10-3-7. Invoices [AMENDED]
**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-923; filed 5-24-13]*

## TITLE 260. ~~OFFICE OF STATE FINANCE~~OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
## CHAPTER 15. ACCESSIBILITY OF INFORMATION TECHNOLOGY

*[OAR Docket #13-924]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
260:15-1-1. Purpose [AMENDED]
260:15-1-2. Definitions [AMENDED]
260:15-1-3. Information technology accessibility standards [AMENDED]
260:15-1-5. Accessibility compliance representative [AMENDED]
260:15-1-6. Filing a formal complaint [AMENDED]
260:15-1-7. Processing a complaint [AMENDED]
260:15-1-8. Disagreement with final complaint response [AMENDED]
260:15-1-9. Annual complaint report [AMENDED]
**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-924; filed 5-24-13]*

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

*[OAR Docket #13-787]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 51. Habilitation Services
317:30-5-482. [AMENDED]
**(Reference APA WF # 12-01A)**

**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-787; filed 5-16-13]*

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

*[OAR Docket #13-789]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 35. Rural Health Clinics
317:30-5-355.1. [AMENDED]
317:30-5-359.2. [AMENDED]
317:30-5-361. [AMENDED]
**(Reference APA WF # 12-03)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-789; filed 5-16-13]*

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

*[OAR Docket #13-790]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-761. [AMENDED]
317:30-5-763. [AMENDED]
317:30-5-763.1. [AMENDED]
317:30-5-764. [AMENDED]
**(Reference APA WF # 12-04A)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-790; filed 5-16-13]*

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

*[OAR Docket #13-792]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 113. Living Choice Program
317:30-5-1200. [AMENDED]
317:30-5-1202. [AMENDED]
317:30-5-1203. [AMENDED]
**(Reference APA WF # 12-05)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-792; filed 5-16-13]*

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

*[OAR Docket #13-794]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 27. Independent Licensed Physical Therapists
317:30-5-291. [AMENDED]
Part 28. Occupational Therapy Services
317:30-5-296. [AMENDED]
Part 77. Speech and Hearing Services
317:30-5-676. [AMENDED]
**(Reference APA WF # 12-07)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-794; filed 5-16-13]*

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

*[OAR Docket #13-795]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. General Provider Policies

Part 1. General Scope and Administration
317:30-3-25. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care ~~Facilities~~Facilities
317:30-5-122. [AMENDED]
**(Reference APA WF # 12-09)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-795; filed 5-16-13]*

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

*[OAR Docket #13-796]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-4. [AMENDED]
Part 39. Skilled Nursing Services
317:30-5-394. [AMENDED]
Part 41. Family Support Services
317:30-5-413. [AMENDED]
Part 43. Agency Companion, Specialized Foster Care, Daily Living Supports, Group Homes, and Community Transition Services
317:30-5-424. [AMENDED]
Part 51. Habilitation Services
317:30-5-483. [AMENDED]
Part 53. Specialized Foster Care
317:30-5-499. [AMENDED]
Part 55. Respite Care
317:30-5-519. [AMENDED]
Part 59. Homemaker Services
317:30-5-538. [AMENDED]
**(Reference APA WF # 12-13)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-796; filed 5-16-13]*

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

*[OAR Docket #13-797]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 19. Nurse Midwives
317:30-5-225. [AMENDED]
317:30-5-226. [AMENDED]
317:30-5-229. [NEW]
Part 87. Birthing Centers
317:30-5-890. [AMENDED]
317:30-5-890.1. [NEW]
317:30-5-891. [AMENDED]
**(Reference APA WF # 12-14)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-797; filed 5-16-13]*

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

*[OAR Docket #13-798]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
317:30-5-240. [AMENDED]
317:30-5-240.1. [AMENDED]
317:30-5-240.2. [AMENDED]
317:30-5-240.3. [AMENDED]
317:30-5-241. [AMENDED]
317:30-5-241.2. [AMENDED]
317:30-5-241.3. [AMENDED]
317:30-5-248. [AMENDED]
Part 25. Psychologists
317:30-5-276. [AMENDED]
Part 26. Licensed Behavioral Health Providers
317:30-5-281. [AMENDED]
Part 67. Behavioral Health Case Management Services
317:30-5-595. [AMENDED]
317:30-5-596.1. [AMENDED]
**(Reference APA WF # 12-19)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-798; filed 5-16-13]*

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

*[OAR Docket #13-799]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-27. [AMENDED]
**(Reference APA WF # 12-20)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-799; filed 5-16-13]*

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

*[OAR Docket #13-800]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 33. Transportation by Ambulance
317:30-5-335.1. [AMENDED]
317:30-5-336.4. [AMENDED]
317:30-5-336.5. [AMENDED]
317:30-5-336.13. [AMENDED]
**(Reference APA WF # 12-22)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-800; filed 5-16-13]*

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

*[OAR Docket #13-801]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-64. [NEW]
Subchapter 5. Individual Providers and Specialties
Part 32. SoonerRide Non-Emergency Transportation
317:30-5-327. [AMENDED]
317:30-5-328. [REVOKED]
**(Reference APA WF # 12-23A)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-801; filed 5-16-13]*

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

*[OAR Docket #13-804]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
317:30-5-699. [AMENDED]
317:30-5-700. [AMENDED]
**(Reference APA WF # 12-25)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-804; filed 5-16-13]*

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

*[OAR Docket #13-810]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-58. [AMENDED]
**(Reference APA WF # 12-33)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-810; filed 5-16-13]*

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

*[OAR Docket #13-812]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-14. [AMENDED]
**(Reference APA WF # 12-35)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-812; filed 5-16-13]*

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

*[OAR Docket #13-813]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 18. Genetic Counselors
317:30-5-221. [AMENDED]
317:30-5-223. [AMENDED]
**(Reference APA WF # 12-37)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-813; filed 5-16-13]*

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

*[OAR Docket #13-814]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-28. [AMENDED]
**(Reference APA WF # 12-38)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-814; filed 5-16-13]*

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

*[OAR Docket #13-815]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-2. [AMENDED]
**(Reference APA WF # 12-39)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-815; filed 5-16-13]*

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

*[OAR Docket #13-816]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95.25. [AMENDED]
317:30-5-95.29. [AMENDED]
317:30-5-95.33. through 317:30-5-95.35. [AMENDED]
317:30-5-95.37. [AMENDED]
317:30-5-95.41. [AMENDED]
317:30-5-95.42. [AMENDED]
**(Reference APA WF # 12-40)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-816; filed 5-16-13]*

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

*[OAR Docket #13-817]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. General Provider Policies
Part 5. Eligibility
317:30-3-70. [REVOKED]
317:30-3-71. [REVOKED]
317:30-3-75. [REVOKED]
317:30-3-77. [REVOKED]
317:30-3-81. [REVOKED]
317:30-3-85. [REVOKED]
317:30-3-86. [REVOKED]
317:30-3-87. [REVOKED]
**(Reference APA WF # 12-41A)**
**GUBERNATORIAL APPROVAL:**
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*[OAR Docket #13-817; filed 5-16-13]*

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

*[OAR Docket #13-819]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 4. Long Term Care Hospitals
317:30-5-66. [AMENDED]
317:30-5-67. [AMENDED]
**(Reference APA WF # 12-42)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-819; filed 5-16-13]*

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

*[OAR Docket #13-820]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care ~~Faciliies~~Facilities
317:30-5-131.1. [AMENDED]
317:30-5-131.2. [AMENDED]
317:30-5-132. [AMENDED]
317:30-5-133. [AMENDED]
**(Reference APA WF # 12-43)**
**GUBERNATORIAL APPROVAL:**
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*[OAR Docket #13-820; filed 5-16-13]*

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

*[OAR Docket #13-791]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 17. ADvantage Waiver Services
317:35-17-3. [AMENDED]
317:35-17-14. [AMENDED]
**(Reference APA WF # 12-04B)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-791; filed 5-16-13]*

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

*[OAR Docket #13-793]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41.6. [AMENDED]
**(Reference APA WF # 12-06)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-793; filed 5-16-13]*

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

*[OAR Docket #13-802]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. Coverage and Exclusions
317:35-3-2. [AMENDED]
**(Reference APA WF # 12-23B)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-802; filed 5-16-13]*

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

*[OAR Docket #13-806]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 7. Determination of Financial Eligibility
317:35-9-68. [AMENDED]
Subchapter 19. Nursing Facility Services
317:35-19-21. [AMENDED]
**(Reference APA WF # 12-29)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-806; filed 5-16-13]*

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

*[OAR Docket #13-811]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 15. Personal Care Services
317:35-15-8. [AMENDED]
317:35-15-13.2. [AMENDED]
**(Reference APA WF # 12-34)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-811; filed 5-16-13]*

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

*[OAR Docket #13-818]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 1. General Provisions
317:35-1-1. [AMENDED]
317:35-1-2. [AMENDED]
317:35-1-3. [AMENDED]
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-1. [AMENDED]
317:35-5-2. [AMENDED]
317:35-5-6. [AMENDED]
317:35-5-6.1. [AMENDED]
317:35-5-7. [AMENDED]
317:35-5-8. [AMENDED]
Part 5. Countable Income and Resources
317:35-5-43. [AMENDED]
317:35-5-44. [AMENDED]
317:35-5-45. [AMENDED]
317:35-5-46. [AMENDED]
Part 7. Application and Eligibility Determination Procedures [NEW]
317:35-5-60. [NEW]
317:35-5-61. [RESERVED]
317:35-5-62. [RESERVED]
317:35-5-63. [NEW]
317:35-5-64. [NEW]
Subchapter 6. SoonerCare for Pregnant Women and Families with Children
Part 1. General
317:35-6-1. [AMENDED]
Part 3. Application Procedures
317:35-6-15. [AMENDED]
Part 5. Determination of Eligibility for SoonerCare for Pregnant Women and Families with Children
317:35-6-35. [AMENDED]
317:35-6-36. [AMENDED]
317:35-6-37. [AMENDED]
317:35-6-38. [REVOKED]
317:35-6-39. [NEW]
317:35-6-40. [NEW]
317:35-6-41. [NEW]
317:35-6-42. [NEW]

317:35-6-43. [NEW]
317:35-6-44. [NEW]
Part 6. Countable Income for MAGI [NEW]
317:35-6-50. [NEW]
317:35-6-51. [NEW]
317:35-6-52. [NEW]
317:35-6-53. [NEW]
317:35-6-54. [NEW]
Part 7. Certification, Redetermination and Notification
317:35-6-60. [AMENDED]
317:35-6-60.1. [NEW]
317:35-6-61. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
317:35-7-15. [REVOKED]
Part 5. Determination of Eligibility for Medical Services
317:35-7-35. [REVOKED]
317:35-7-37. [REVOKED]
317:35-7-48. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-7-60.1. [AMENDED]
317:35-7-63. [REVOKED]
317:35-7-64. [REVOKED]
317:35-7-65. [REVOKED]
317:35-7-66. [REVOKED]
Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 7. Determination of Financial Eligibility
317:35-9-67. [AMENDED]
Part 9. Certification, Redetermination and Notification
317:35-9-75. [AMENDED]
Subchapter 10. Other Eligibility Factors for Families with Children and Pregnant Women
Part 3. Resources
317:35-10-10. [AMENDED]
Part 5. Income
317:35-10-25. [AMENDED]
317:35-10-26. [AMENDED]
Subchapter 13. Member Rights and Responsibilities
317:35-13-1. [AMENDED]
317:35-13-2. [AMENDED]
Subchapter 15. Personal Care Services
317:35-15-5. [AMENDED]
317:35-15-6. [AMENDED]
317:35-15-7. [AMENDED]
Subchapter 19. Nursing Facility Services
317:35-19-19. [AMENDED]
317:35-19-20. [AMENDED]
317:35-19-22. [AMENDED]
Subchapter 21. Oklahoma Cares Breast and Cervical Cancer Treatment Program
317:35-21-13. [AMENDED]
**(Reference APA WF # 12-41B)**

**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-818; filed 5-16-13]*

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## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

*[OAR Docket #13-788]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Member Services
Part 9. Service Provisions
317:40-5-110. [AMENDED]
**(Reference APA WF # 12-01B)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-788; filed 5-16-13]*

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## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

*[OAR Docket #13-805]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Member Services
Part 1. Agency Companion Services
317:40-5-5. [AMENDED]
Part 5. Specialized Foster Care
317:40-5-55. [AMENDED]
317:40-5-61. [REVOKED]
**(Reference APA WF # 12-27)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-805; filed 5-16-13]*

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## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 45. INSURE OKLAHOMA

*[OAR Docket #13-803]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 1. General Provisions
317:45-1-2 [AMENDED]
Subchapter 11. Insure Oklahoma IP
Part 3. Insure Oklahoma IP Member Health Care Benefits
317:45-11-10 [AMENDED]
**(Reference APA WF # 12-24)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-803; filed 5-16-13]*

## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

*[OAR Docket #13-807]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 1. Medically Fragile Waiver Services
317:50-1-3. [AMENDED]
317:50-1-6. [AMENDED]
317:50-1-14. [AMENDED]
**(Reference APA WF # 12-30)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-807; filed 5-16-13]*

## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

*[OAR Docket #13-808]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. My Life, My Choice
317:50-3-3. [AMENDED]
317:50-3-6. [AMENDED]
317:50-3-14. [AMENDED]
**(Reference APA WF # 12-31)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-808; filed 5-16-13]*

## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

*[OAR Docket #13-809]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 5. Sooner Seniors
317:50-5-3. [AMENDED]
317:50-5-6. [AMENDED]
317:50-5-14. [AMENDED]
**(Reference APA WF # 12-32)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-809; filed 5-16-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 1. FUNCTION AND STRUCTURE OF THE ~~DEPARTMENT~~OKLAHOMA DEPARTMENT OF HUMAN SERVICES

*[OAR Docket #13-756]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 1. General Provisions
340:1-1-1 through 340:1-1-2 [AMENDED]
340:1-1-3 [REVOKED]
340:1-1-4 [AMENDED]
340:1-1-17 [AMENDED]
340:1-1-18 [REVOKED]
340:1-1-19 [AMENDED]
**(Reference WF 12-22)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-756; filed 5-15-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 2. ADMINISTRATIVE COMPONENTS

*[OAR Docket #13-757]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 3. Office of Client Advocacy

Part 1. Administration
340:2-3-2 [AMENDED]
Part 3. Investigations
340:2-3-33 through 340:2-3-34 [AMENDED]
**(Reference WF 12-09)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-757; filed 5-15-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 2. ADMINISTRATIVE COMPONENTS

*[OAR Docket #13-758]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 31. ~~Legislative~~Intergovernmental Relations and Policy
Part 4. Office of ~~Legislative~~Intergovernmental Relations and Policy
340:2-31-10 [AMENDED]
Part 5. Petitioning for Rulemaking
340:2-31-31 through 340:2-31-33 [AMENDED]
Subchapter 33. Rates and Standards
340:2-33-1 through 340:2-33-3 [AMENDED]
**(Reference WF 12-23)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-758; filed 5-15-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 2. ADMINISTRATIVE COMPONENTS

*[OAR Docket #13-759]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 1. Human Resources Management Division (HRMD)
Part 5. Administrative Procedures
340:2-1-57 [REVOKED]
**(Reference APA WF 12-04)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-759; filed 5-15-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

*[OAR Docket #13-760]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 3. Conditions of Eligibility - Need
Part 5. Assistance Payments
340:10-3-57 [AMENDED]
Subchapter 4. Mandatory Drug Screening [NEW]
340:10-4-1 [NEW]
**(Reference APA WF 12-20)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-760; filed 5-15-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 25. OKLAHOMA CHILD SUPPORT SERVICES

*[OAR Docket #13-761]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 5. Operational Policies
Part 21. Establishment.
340:25-5-179.1 [AMENDED]
**(Reference WF 12-12)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-761; filed 5-15-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 40. CHILD CARE SUBSIDY PROGRAM

*[OAR Docket #13-762]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 7. Eligibility
340:40-7-6 [AMENDED]
340:40-7-11 [AMENDED]
**(Reference APA WF 12-13)**

**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-762; filed 5-15-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 50. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

*[OAR Docket #13-763]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 9. Eligibility and Benefit Determination Procedures
340:50-9-3 [AMENDED]
**(Reference APA WF12-19)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-763; filed 5-15-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 61. REPATRIATION PROGRAM

*[OAR Docket #13-764]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 1. General Provisions [NEW]
340:61-1-1 through 340:61-1-4 [NEW]
**(Reference APA WF 12-25)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-764; filed 5-15-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 75. CHILD WELFARE

*[OAR Docket #13-765]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 1. General Provisions of Child Welfare Services
Part 9. Rules Regarding Human Immunodeficiency Virus (HIV)
340:75-1-113 [AMENDED]
Subchapter 3. Child Protective Services
340:75-3-100 [NEW]
340:75-3-300 [NEW]
Subchapter 6. Permanency Planning
Part 7. Family and Child Individualized Service Planning Components
340:75-6-40.9 [NEW]
Part 8. ~~Role of the~~ Child Welfare ~~Worker~~Specialist Role
340:75-6-48.1 [AMENDED]
Part 11. Permanency Planning and Placement Services
340:75-6-85 [AMENDED]
Subchapter 7. Foster Home Care
Part 4. Roles and Responsibilities
340:75-7-38 [AMENDED]
Part 25. Emergency Foster Care Program
340:75-7-262 [AMENDED]
Subchapter 15. Adoptions
Part 10. Integrated Family Assessment and Preparation Process
340:75-15-87 [AMENDED]
**(Reference WF 12-10)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-765; filed 5-15-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES DIVISION

*[OAR Docket #13-766]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 3. Administration
Part 1. General Administration
340:100-3-5.1 [AMENDED]
**(Reference WF 12-08)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-766; filed 5-15-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 110. LICENSING SERVICES

*[OAR Docket #13-767]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 1. General Provisions
Part 1. Licensing Services - Child Care

340:110-1-4.1 [AMENDED]
340:110-1-9.2 through 340:110-1-9.3 [AMENDED]
Part 3. Licensing Services - Residential Care and Agencies
340:110-1-43.1 [AMENDED]
340:110-1-47.1 through 340:110-1-47.2 [AMENDED]
**(Reference WF 12-24)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-767; filed 5-15-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 110. LICENSING SERVICES

*[OAR Docket #13-768]*

**RULEMAKING ACTION:**
Gubernatorial approval of Permanent rules
**RULES:**
Subchapter 3. Licensing Standards for Child Care Facilities
Part 1. Requirements for Child Care Centers
340:110-3-14 [AMENDED]
Part 2. ~~Requirement~~Requirements for Part-Day Children's Programs
340:110-3-45 [AMENDED]
Part 5. Requirements for Family Child Care Homes and Large Family Child Care Homes
340:110-3-91.1 [AMENDED]
Part 9. Requirements for Residential Child Care Facilities
340:110-3-157 [AMENDED]
**(Reference WF 12-26)**
**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-768; filed 5-15-13]*

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## TITLE 530. OFFICE OF PERSONNEL MANAGEMENT
## CHAPTER 10. MERIT SYSTEM OF PERSONNEL ADMINISTRATION RULES

*[OAR Docket #13-946]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Chapter 10. Merit System of Personnel Administration Rules [AMENDED]
**GUBERNATORIAL APPROVAL:**
May 6, 2013.

*[OAR Docket #13-946; filed 5-29-13]*

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## TITLE 580. DEPARTMENT OF CENTRAL SERVICES
## CHAPTER 16. CENTRAL PURCHASING

*[OAR Docket #13-916]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 3. Supplier Provisions
580:16-3-21. Supplier's protest [AMENDED]
**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-916; filed 5-24-13]*

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## TITLE 580. DEPARTMENT OF CENTRAL SERVICES
## CHAPTER 20. CONSTRUCTION AND PROPERTIES

*[OAR Docket #13-917]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 27. Use of Best Value Competitive Proposals to Award a Contract
580:20-27-7. Vendor selection [NEW]
**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-917; filed 5-24-13]*

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## TITLE 580. DEPARTMENT OF CENTRAL SERVICES
## CHAPTER 55. ALTERNATIVE FUELS PROGRAM

*[OAR Docket #13-918]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**RULES:**
Subchapter 1. General Provisions
580:55-1-21. Purpose [AMENDED]
580:55-1-23. Definitions [AMENDED]
Subchapter 5. Testing, Certification and Recertification
580:55-5-2. Contents of application [AMENDED]
580:55-5-10. Certificate qualification and transfer or loan of certificate [AMENDED]
Subchapter 7. Standards for Alternative Fuels Technicians-Conversion and Compression
580:55-7-4. Decals and conversion reporting procedure [AMENDED]

Subchapter 9. Violations
580:55-9-1. Alternative Fuels Technician Hearing Board; complaints, investigations, false or fraudulent representation, suspension or revocation of certificate [AMENDED]

**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-918; filed 5-24-13]*

## TITLE 605. OKLAHOMA REAL ESTATE COMMISSION
## CHAPTER 1. ADMINISTRATIVE OPERATIONS

*[OAR Docket #13-821]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 1. General Provisions
605:1-1-4. [AMENDED]

**GUBERNATORIAL APPROVAL:**
April 29 2013

*[OAR Docket #13-821; filed 5-16-13]*

## TITLE 605. OKLAHOMA REAL ESTATE COMMISSION
## CHAPTER 10. REQUIREMENTS, STANDARDS AND PROCEDURES

*[OAR Docket #13-822]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 1. General Provisions
605:10-1-2. [AMENDED]
Subchapter 5. Instructor and Entity Requirements and Standards
605:10-5-1. [AMENDED]
605:10-5-1.1 [AMENDED]
605:10-5-2. [AMENDED]
Subchapter 7. Licensing Procedures and Options
605:10-7-2. [AMENDED]
605:10-7-7. [AMENDED]
605:10-7-9. [AMENDED]
605:10-7-10. [AMENDED]
Subchapter 9. Broker's Operational Procedures
605:10-9-4. [AMENDED]
Subchapter 15. Disclosures
605:10-15-2. [AMENDED]
Subchapter 17. Causes for Investigation; Hearing Process; Prohibited Acts; Discipline
605:10-17-4. [AMENDED]

**GUBERNATORIAL APPROVAL:**
April 29, 2013

*[OAR Docket #13-822; filed 5-16-13]*

## TITLE 660. DEPARTMENT OF SECURITIES
## CHAPTER 2. ORGANIZATION AND PROCEDURES OF DEPARTMENT OF SECURITIES

*[OAR Docket #13-929]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 9. Individual Proceeding Practices and Procedures
660:2-9-3. [AMENDED]
660:2-9-4. [AMENDED]
660:2-9-6. [AMENDED]

**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-929; filed 5-24-13]*

## TITLE 660. DEPARTMENT OF SECURITIES
## CHAPTER 11. OKLAHOMA UNIFORM SECURITIES ACT OF 2004

*[OAR Docket #13-928]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 1. General Provisions
660:11-1-3. [AMENDED]
Subchapter 5. Broker-Dealers and Agents
Part 1. General Provisions
660:11-5-1. [AMENDED]
660:11-5-2. [AMENDED]
PART 3. Licensing Procedures
660:11-5-11. [AMENDED]
660:11-5-12. [AMENDED]
660:11-5-13. [AMENDED]
660:11-5-14. [AMENDED]
660:11-5-16. [AMENDED]
Part 5. Reporting Requirements
660:11-5-31. [AMENDED]
Part 7. Record Keeping and Ethical Standards
660:11-5-42. [AMENDED]
Subchapter 7. Investment Advisers and Investment Adviser Representatives
Part 1. General Provisions
660:11-7-1. [AMENDED]

Part 3. Licensing Procedures
660:11-7-11. [AMENDED]
660:11-7-13. [AMENDED]
660:11-7-17. [NEW]
Part 5. Reporting requirements
660:11-7-31 [AMENDED]
Part 7. Record Keeping and Ethical Standards
660:11-7-41. [AMENDED]
660:11-7-42. [AMENDED]
660:11-7-43. [AMENDED]
660:11-7-47. [AMENDED]
660:11-7-48. [AMENDED]
Part 9. SEC Covered Investment Advisers
660:11-7-51. [AMENDED]
Subchapter 13. Sales Literature
660:11-13-2. [AMENDED]
660:11-13-3. [AMENDED]
660:11-13-4. [AMENDED]

**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-928; filed 5-24-13]*

## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 10. AD VALOREM

*[OAR Docket #13-872]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**PROPOSED RULES:**
Subchapter 4. Annual Valuation Mandate [REVOKED]
710:10-4-1 [REVOKED]
710:10-4-2 [REVOKED]
710:10-4-3 [REVOKED]
710:10-4-6 [REVOKED]
710:10-4-7 [REVOKED]
710:10-4-8 [REVOKED]
710:10-4-9 [REVOKED]

**GUBERNATORIAL APPROVAL:**
April 22, 2013

*[OAR Docket #13-872; filed 5-22-13]*

## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 20. ALCOHOL, MIXED BEVERAGES, AND LOW-POINT BEER

*[OAR Docket #13-873]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**PROPOSED RULES:**
Subchapter 2. Low-Point Beer
Part 1. General Provisions
710:20-2-5 [AMENDED]
Subchapter 3. Alcoholic Beverages
710:20-3-4 [AMENDED]

**GUBERNATORIAL APPROVAL:**
April 22, 2013

*[OAR Docket #13-873; filed 5-22-13]*

## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 22. BOATS AND MOTORS

*[OAR Docket #13-874]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**PROPOSED RULES:**
Subchapter 1. General Provisions
710:22-1-3 [AMENDED]

**GUBERNATORIAL APPROVAL:**
April 18, 2013

*[OAR Docket #13-874; filed 5-22-13]*

## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 50. INCOME

*[OAR Docket #13-875]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**PROPOSED RULES:**
Subchapter 11. Intercept of Refunds
710:50-11-6 [AMENDED]
710:50-11-7 [AMENDED]
710:50-11-9 [AMENDED]
710:50-11-10 [AMENDED]
710:50-11-11 [AMENDED]
Subchapter 15. Oklahoma Taxable Income
Part 7. Credits against Tax
710:50-15-74 [AMENDED]
710:50-15-94 [AMENDED]
Subchapter 19. Oklahoma Taxable Income for Partnerships
710:50-19-1 [AMENDED]

**GUBERNATORIAL APPROVAL:**
April 18, 2013

*[OAR Docket #13-875; filed 5-22-13]*

## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 60. MOTOR VEHICLES

*[OAR Docket #13-876]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**PROPOSED RULES:**
Subchapter 3. Registration and Licensing
Part 3. Penalties
710:60-3-37 [AMENDED]
Part 5. Dealers
710:60-3-54 [AMENDED]
Part 9. Commercial Vehicles
710:60-3-91 [AMENDED]
710:60-3-97 [AMENDED]
Part 17. Special Permits
710:60-3-202 [AMENDED]
Subchapter 5. Motor Vehicle Titles
Part 5. Certificates of Title
710:60-5-65 [NEW]
Part 7. Transfer of Title
710:60-5-71 [AMENDED]
Part 9. Affidavits for Use in Titles
710:60-5-91 [AMENDED]
710:60-5-97 [NEW]
710:60-5-98 [NEW]
Subchapter 9. Motor Vehicle License Agents/Agencies
Part 13. Provisions for Motor License Agent Application and Appointment
710:60-9-137 [AMENDED]
710:60-9-138 [NEW]
**GUBERNATORIAL APPROVAL:**
April 18, 2013

*[OAR Docket #13-876; filed 5-22-13]*

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## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 60. MOTOR VEHICLES

*[OAR Docket #13-877]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**PROPOSED RULES:**
Subchapter 8. Rental Tax on Motor Vehicle Rentals [REVOKED]
710:60-8-1 [REVOKED]
710:60-8-2 [REVOKED]
710:60-8-3 [REVOKED]
710:60-8-4 [REVOKED]
710:60-8-5 [REVOKED]
710:60-8-6 [REVOKED]
**GUBERNATORIAL APPROVAL:**
April 18, 2013

*[OAR Docket #13-877; filed 5-22-13]*

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## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 70. TOBACCO, TOBACCO PRODUCTS, AND CIGARETTES

*[OAR Docket #13-878]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**PROPOSED RULES:**
Subchapter 2. Cigarette Stamp Tax
Part 3. Delivery Sales
710:70-2-50 [AMENDED]
Subchapter 5. Excise on Tobacco Products
710:70-5-2 [AMENDED]
710:70-5-3 [AMENDED]
710:70-5-5 [AMENDED]
710:70-5-8 [AMENDED]
710:70-5-10 [REVOKED]
**GUBERNATORIAL APPROVAL:**
April 22, 2013

*[OAR Docket #13-878; filed 5-22-13]*

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## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 95. MISCELLANEOUS AREAS OF REGULATORY AND ADMINISTRATIVE AUTHORITY

*[OAR Docket #13-879]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules
**PROPOSED RULES:**
Subchapter 3. Telecommunication for the Hearing-Impaired Surcharge
710:95-3-3 [AMENDED]
Subchapter 4. Rental Tax on Motor Vehicle Rentals [NEW]
710:95-4-1 [NEW]
710:95-4-2 [NEW]
710:95-4-3 [NEW]
710:95-4-4 [NEW]
710:95-4-5 [NEW]
710:95-4-6 [NEW]
Subchapter 5. Used Tire Recycling
710:95-5-3 [AMENDED]
710:95-5-8 [AMENDED]
710:95-5-9 [AMENDED]

Subchapter 22. Registration Requirements for Resident and Nonresident Contractors [NEW]
710:95-22-1 [NEW]
710:95-22-2 [NEW]
710:95-22-3 [NEW]
710:95-22-4 [NEW]
710:95-22-5 [NEW]
710:95-22-6 [NEW]
710:95-22-7 [NEW]
710:95-22-8 [NEW]
710:95-22-9 [NEW]

**GUBERNATORIAL APPROVAL:**
April 18, 2013

*[OAR Docket #13-879; filed 5-22-13]*

## TITLE 780. OKLAHOMA DEPARTMENT OF CAREER AND TECHNOLOGY EDUCATION CHAPTER 10. ADMINISTRATION AND SUPERVISION

*[OAR Docket #13-864]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 7. Local Programs, Career Majors or Instructional Positions: Application; Student Accounting; Evaluation
780:10-7-2. [AMENDED]
Subchapter 9. Service Contracts and Equipment Guidelines
780:10-9-2 [AMENDED]

**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-864; filed 5-21-13]*

## TITLE 780. OKLAHOMA DEPARTMENT OF CAREER AND TECHNOLOGY EDUCATION CHAPTER 15. TECHNOLOGY CENTERS

*[OAR Docket #13-865]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 3. Technology Centers Education
780:15-3-2. [AMENDED]

**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-865; filed 5-21-13]*

## TITLE 780. OKLAHOMA DEPARTMENT OF CAREER AND TECHNOLOGY EDUCATION CHAPTER 20. PROGRAMS AND SERVICES

*[OAR Docket #13-866]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 3. Secondary, Full-time and Short-term Adult CareerTech Programs
780:20-3-2. [AMENDED]

**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-866; filed 5-21-13]*

## TITLE 780. OKLAHOMA DEPARTMENT OF CAREER AND TECHNOLOGY EDUCATION CHAPTER 25. BUSINESS AND INDUSTRY SERVICES

*[OAR Docket #13-867]*

**RULEMAKING ACTION:**
Gubernatorial approval of permanent rules

**RULES:**
Subchapter 5. Business and Industry Development
780:25-5-1. [AMENDED]

**GUBERNATORIAL APPROVAL:**
May 6, 2013

*[OAR Docket #13-867; filed 5-21-13]*

# Withdrawn Rules

An agency may withdraw proposed PERMANENT rules prior to final adoption (approval by Governor/Legislature) by notifying the Governor and the Legislature and by publishing a notice in the *Register* of such a withdrawal.

An agency may withdraw proposed EMERGENCY rules prior to approval/disapproval by the Governor by notifying the Governor, the Legislature, and the Office of Administrative Rules. The withdrawal notice is not published in the *Register*, however, unless the agency published a Notice of Rulemaking Intent in the *Register* before adopting the EMERGENCY rules.

*For additional information on withdrawal of proposed rules, see 75 O.S., Section 308(F) and 253(K) and OAC 655:10-7-33.*

## TITLE 230. STATE ELECTION BOARD
## CHAPTER 45. CONTESTS OF ELECTION

*[OAR Docket #13-773]*

**RULEMAKING ACTION:**
Withdrawal of PERMANENT rulemaking
**WITHDRAWN RULES:**
Subchapter 3. Recounts
Part 9. Recounts with Electronic Voting Devices
230:45-3-52
**DATES:**
**Adoption:**
March 27, 2013
**Submitted to Governor:**
April 1, 2013
**Submitted to House:**
April 1, 2013
**Submitted to Senate:**
April 1, 2013
**Withdrawn:**
May 15, 2013

*[OAR Docket #13-773; filed 5-15-13]*

## TITLE 595. DEPARTMENT OF PUBLIC SAFETY
## CHAPTER 1. GENERAL RULES OF THE DEPARTMENT OF PUBLIC SAFETY

*[OAR Docket #13-827]*

**RULEMAKING ACTION:**
Withdrawal of PERMANENT rulemaking
**WITHDRAWN RULES:**
Subchapter 3. Rules of Practice
595:1-3-4 [AMENDED]
595:1-3-19 [AMENDED]
**DATES:**
**Adoption:**
March 28, 2013
**Submitted to Governor:**
March 29, 2013
**Submitted to House:**
March 29, 2013
**Submitted to Senate:**
March 29, 2013
**Withdrawn:**
May 10, 2013

*[OAR Docket #13-827; filed 5-20-13]*

## TITLE 595. DEPARTMENT OF PUBLIC SAFETY
## CHAPTER 25. WRECKERS AND TOWING SERVICES

*[OAR Docket #13-828]*

**RULEMAKING ACTION:**
Withdrawal of PERMANENT rulemaking
**WITHDRAWN RULES:**
Chapter 25. Wreckers and Towing Services [AMENDED]
**DATES:**
**Adoption:**
March 28, 2013
**Submitted to Governor:**
March 29, 2013
**Submitted to House:**
March 29, 2013
**Submitted to Senate:**
March 29, 2013
**Withdrawn:**
May 6, 2013

*[OAR Docket #13-828; filed 5-20-13]*

## TITLE 595. DEPARTMENT OF PUBLIC SAFETY
## CHAPTER 30. SIZE AND WEIGHT PERMITS

*[OAR Docket #13-829]*

**RULEMAKING ACTION:**
Withdrawal of PERMANENT rulemaking
**WITHDRAWN RULES:**
Chapter 30. Size and Weight Permits [AMENDED]
**DATES:**
**Adoption:**
March 28, 2013
**Submitted to Governor:**
March 29, 2013

## Withdrawn Rules

**Submitted to House:**
March 29, 2013
**Submitted to Senate:**
March 29, 2013

**Withdrawn:**
May 6, 2013

*[OAR Docket #13-829; filed 5-20-13]*

# Permanent Final Adoptions

An agency may promulgate rules on a permanent basis upon "final adoption" of the proposed new, amended, or revoked rules. "Final adoption" occurs upon approval by the Governor and the Legislature, or upon enactment of a joint resolution of approval by the Legislature. Before proposed permanent rules can be reviewed and approved/disapproved by the Governor and the Legislature, the agency must provide the public an opportunity for input by publishing a Notice of Rulemaking Intent in the *Register.*

Permanent rules are effective ten days after publication in the *Register*, or on a later date specified by the agency in the preamble of the permanent rule document.

Permanent rules are published in the *Oklahoma Administrative Code*, along with a source note entry that references the *Register* publication of the permanent action.

*For additional information on the permanent rulemaking process, see 75 O.S., Sections 303, 303.1, 303.2, 308 and 308.1.*

## TITLE 160. DEPARTMENT OF CONSUMER CREDIT
## CHAPTER 3. PROCEDURE

*[OAR Docket #13-898]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
160:3-1-4 [AMENDED]
**AUTHORITY:**
Administrator of Consumer Credit; 14A O.S. § 6-104(1)(e); 75 O.S. § 302(A).
**DATES:**
**Comment period:**
February 1, 2013 through March 6, 2013
**Public hearing:**
March 6, 2013
**Adoption:**
March 13, 2013
**Submitted to Governor:**
March 18, 2013
**Submitted to House:**
March 18, 2013
**Submitted to Senate:**
March 18, 2013
**Gubernatorial approval:**
April 18, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 15, 2013
**Final adoption:**
May 15, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATION BY REFERENCE:**
n/a
**ANALYSIS:**
The rule amendment requires the Administrator to issue a Final Agency Order regarding an individual proceeding that has not been resolved pursuant to a Consent Order. The rule amendment requires the Administrator to issue a Final Agency Order within a reasonable period of time after reviewing the administrative record and a proposed order from the hearing examiner. The rule amendment also requires the Administrator to schedule a hearing within twenty (20) days from the date of service of an emergency order.
**CONTACT PERSON:**
Roy John Martin, General Counsel, Department of Consumer Credit, 3613 N.W. 56th Street, Suite 240, Oklahoma City, OK 73112, 405-522-4665.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE IS CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

**160:3-1-4. Requirements for individual proceedings**

(a) **Purpose.** The purpose of this rule is to prescribe procedures and requirements for references of parties, entries of appearance, continuances, subpoenas and Consent Orders for individual proceedings at the Department of Consumer Credit (Department). This rule supplements rules in subsequent chapters of this title concerning individual proceedings and hearing procedures. Any conflicts between this rule and rules in subsequent chapters of this title concerning individual proceedings and hearing procedures shall be resolved in favor of the requirements of this rule.

(b) **Definition of individual proceeding.** For purposes of this rule, individual proceeding has the same meaning as defined in 75 O.S. § 250.3.

(c) **Computation of time.** For purposes of this rule and any subsequent rules in this title concerning individual proceedings and hearing requirements, computation of time shall be as provided in 75 O.S. § 250.8.

(d) **Names of parties.** The Department shall be referred to as the Petitioner in an individual proceeding. A licensee or any entity or individual that is the subject of an individual proceeding initiated by the Department shall be referred to as the Respondent.

(e) **Entry of Appearance.** Attorneys representing the Department and attorneys representing Respondents in an individual proceeding shall file an entry of appearance. The entry of appearance shall include the case caption of the individual proceeding, the name, address, telephone number, electronic mail address and Oklahoma Bar Association number of the attorney filing an entry of appearance. An attorney filing an entry of appearance shall also indicate the party being represented by the attorney.

(f) **Continuances.**

(1) **Continuance motion by the Respondent.** A Respondent that wishes to continue a scheduled hearing pursuant to an individual proceeding shall file a motion for continuance with the Department. The motion for continuance shall be in writing, shall indicate the reason(s) for the requested continuance, shall include the signature of the Respondent or attorney representing the Respondent and shall be filed at least seven (7) calendar days prior to the scheduled hearing date. The calendar day filing requirement may be waived by the hearing examiner for good cause shown, upon motion of the Respondent.

(2) **Continuance by the Department.** The Department may continue a scheduled hearing pursuant to an individual proceeding by submitting written notification

to the Respondent via certified mail, return receipt requested, or electronic mail at least seven (7) calendar days prior to the scheduled hearing date. The attorney for the Department shall prepare and sign the continuance order. The continuance order shall be filed at the Department. The submission date shall be the date a continuance is mailed to the Respondent. The calendar day notification requirement may be waived by the hearing examiner for good cause shown, upon motion of the Department.

(3) **Contested continuance motions.** If the Department opposes a motion for continuance filed by the Respondent, the attorney for the Department shall file a motion opposing the motion for continuance and include the reasons why the Department opposes the motion for continuance. The motion for continuance and the motion opposing the continuance shall be submitted to the hearing examiner by the attorney for the Department. The motion for continuance and the motion opposing the continuance shall be submitted via electronic mail at least five (5) calendar days prior to the scheduled hearing. The hearing examiner shall issue an order concerning the contested motion for continuanceat least three (3) calendar days prior to the scheduled hearing. The hearing examiner shall submit the order to the Department and the Respondent via electronic mail. The continuance order shall be filed at the Department.

(4) **Unopposed continuance motions.** If the Department does not object to a motion for continuance filed by the Respondent, the attorney for the Department shall issue and sign a continuance order and shall submit the continuance order to the Respondent via certified mail, return receipt requested or via electronic mail. The continuance order shall be filed at the Department.

(g) **Subpoenas.**

(1) **Subpoenas by the Department.** If the Department wishes to issue a subpoena for document production or testimony concerning any issue involved in an individual proceeding, the attorney for the Department, the Administrator or Deputy Administrator may issue and sign the subpoena. The subpoena shall be served as authorized by the Oklahoma Civil Procedure Code.

(2) **Subpoenas by a Respondent.** If the Respondent wishes to issue a subpoena for document production or testimony concerning any issue involved in an individual proceeding, the Respondent shall submit a written request to the attorney for the Department or Administrator via electronic mail or regular United States mail. The Administrator, Deputy Administrator or the hearing examiner may issue and sign the subpoena. The subpoena shall be served by the Respondent as authorized by the Oklahoma Civil Procedure Code.

(h) **Consent Orders.**

(1) **Process.** After a Notice of Hearing is filed pursuant to an individual proceeding initiated by the Department, a Respondent may waive their right to a hearing and enter into a Consent Order with the Department. A Respondent that wishes to waive their right to a hearing and enter into a Consent Order shall submit notification to the attorney for the Department. The notification may be submitted via electronic mail or regular United States Mail. The notification shall indicate that the Respondent wishes to waive their right to a hearing and enter into a Consent Order with the Department.

(2) **Time requirements.** Notification that a Respondent wishes to enter into a Consent Order shall be received by the Department at least five (5) calendar days prior to the scheduled hearing date. If the written notification is not received within the required period of time, the hearing shall be heard as scheduled unless waived by written agreement of both parties. Upon receipt of notification that a Respondent wishes to enter into a Consent Order, the attorney for the Department shall prepare a Consent Order for signature by the Respondent and the Administrator or Deputy Administrator. A Consent Order shall be signed by both parties and filed within thirty (30) calendar days of receipt of notification that the Respondent wishes to enter into a Consent Order. If a Consent Order is not signed by both parties and filed within the required period of time, a hearing shall be re-scheduled for the next regularly scheduled hearing docket at the Department.

(3) **Signatures.** The Deputy Administrator is authorized to sign any Consent Order entered into by a Respondent and the Department. A Respondent shall verify the truth of the statements contained in a Consent Order in the presence of a notary public.

(i) **Final Agency Orders.** The Administrator shall issue a Final Agency Order regarding an individual proceeding that has not been resolved pursuant to a Consent Order. The Administrator shall issue a Final Agency Order within a reasonable period of time after reviewing the administrative record and a proposed order from the hearing examiner.

(j) **Emergency orders.** The Administrator may issue an emergency order, pending the final outcome of the proceeding, that includes the suspension of a license instanter or a cease and desist instanter if the public health, safety, or welfare imperatively requires such action. An emergency order shall include an order for a hearing that is scheduled within twenty (20) days from the date of service of the emergency order. The Administrator shall serve an emergency order by certified mail, return receipt requested, or by personal delivery.

*[OAR Docket #13-898; filed 5-23-13]*

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## TITLE 160. DEPARTMENT OF CONSUMER CREDIT
## CHAPTER 45. TRUTH IN LENDING RULES

*[OAR Docket #13-899]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
160:45-1-2 [AMENDED]
160:45-1-3 [AMENDED]
Subchapter 5. Closed-End Credit
160:45-5-1 [AMENDED]

160:45-5-3 [AMENDED]
160:45-5-9 [NEW]

**AUTHORITY:**
Administrator of Consumer Credit; 14A O.S. §§ 3-310, 6-104(1)(e) and 6-104(2).

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n/a

**ANALYSIS:**
The rule amendments incorporate federal changes to Regulation Z for purposes of maintaining Oklahoma's exemption from federal enforcement of the consumer credit disclosure provisions of the Truth in Lending Act and Regulation Z. Specifically, the rule amendments implement the enhanced mortgage disclosure requirements that were incorporated into the Uniform Consumer Credit Code by Oklahoma House Bill 2742, which became effective July 1, 2012. The rule amendments also amend the dollar threshold amount for exempt transactions to correspond with revisions made to the Uniform Consumer Credit Code and Regulation Z.

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE IS CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

### 160:45-1-2. Definitions and rules of construction

(a) **Definition.** For purposes of this chapter, the following definitions apply:

(1) **"Administrator"** means the Administrator of the Department.

(2) **"Advertisement"** means a commercial message in any medium that promotes, directly or indirectly, a credit transaction.

(3) **"Billing cycle"** or **"cycle"** means the interval between the days or dates of regular periodic statements. These intervals shall be equal and no longer than a quarter of a year. An interval will be considered equal if the number of days in the cycle does not vary more than four days from the regular day or date of the periodic statement.

(4) **"Board"** means the Board of Governors of the Federal Reserve System.

(5) **"Business day"** means a day on which the creditor's offices are open to the public for carrying on substantially all of its business functions. However, for purposes of rescission under 160:45-3-13 and 160:45-5-7, and for purposes of 160:45-5-3(a)(1)(ii) , 160:45-5-3(a)(2), and 160:45-9-1, the term means all calendar days except Sundays and the legal public holidays specified in 5 USC 6103(a), such as New Year's Day, the Birthday of Martin Luther King, Jr., Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.

(6) **"Card issuer"** means a person that issues a credit card or that person's agent with respect to the card.

(7) **"Cardholder"** means a natural person to whom a credit card is issued for consumer credit purposes, or a natural person who has agreed with the card issuer to pay consumer credit obligations arising from the issuance of a credit card to another natural person.

(8) **"Cash price"** means the price at which a creditor, in the ordinary course of business, offers to sell for cash the property or service that is the subject of the transaction. At the creditor's option, the term may include the price of accessories, services related to the sale, service contracts and taxes and fees for license, title, and registration. The term does not include any finance charge.

(9) **"Closed-end credit"** means consumer credit other than "open-end credit" as defined in this section.

(10) **"Code"** means the Uniform Consumer Credit Code beginning at §1-101 of Title 14A of the Oklahoma Statutes.

(11) **"Consumer"** means a cardholder or a natural person to whom consumer credit is offered or extended. However, for purposes of rescission under 160:45-3-13 and 160:45-5-7, the term also includes a natural person in whose principal dwelling a security interest is or will be retained or acquired, if that person's ownership interest in the dwelling is or will be subject to the security interest.

(12) **"Consumer credit"** means credit offered or extended to a consumer primarily for personal, family, or household purposes.

(13) **"Consummation"** means the time that a consumer becomes contractually obligated on a credit transaction.

(14) **"Credit"** means the right to defer payment of debt or to incur debt and defer its payment.

(15) **"Credit card"** means any card, plate, coupon book, or other single credit device that may be used from time to time to obtain credit. "Charge card" means a credit card on an account for which no periodic rate is used to compute a finance charge.

(16) **"Credit sale"** means a sale in which the seller is a creditor. The term includes a bailment or lease (unless terminable without penalty at any time by the consumer) under which the consumer-

(A) Agrees to pay as compensation for use a sum substantially equivalent to, or in excess of, the total value of the property and services involved; and

(B) Will become (or has the option to become), for no additional consideration or for nominal consideration, the owner of the property upon compliance with the agreement.

(17) **"Creditor"** means:

(A) A person

(i) who regularly extends consumer credit 3/ that is subject to a finance charge or is payable by written agreement in more than four installments (not including a downpayment), and

(ii) to whom the obligation is initially payable, either on the face of the note or contract, or by agreement when there is no note or contract.

(B) For purposes of 160:45-1-4(c)(8) (Discounts) and 160:45-3-7(d) (Finance charge imposed at time of transaction), a person that honors a credit card.

(C) For purposes of subchapter 3, any card issuer that extends either open-end credit or credit that is not subject to a finance charge and is not payable by written agreement in more than four installments.

(D) For purposes of subchapter 3 (except for the credit and charge card disclosures contained in 160:45-3-2 and 160:45-3-7(e) and (f), the finance-charge disclosures contained in 160:45-3-4(1) and 160:45-3-5(4) through (7) and the right of rescission set forth in 160:45-3-13) and subchapter 5, any card issuer that extends closed-end credit that is subject to a finance charge or is payable by written agreement in more than four installments.

(18) **"Department"** means the Oklahoma State Department of Consumer Credit.

(19) **"Downpayment"** means an amount, including the value of any property used as a trade-in, paid to a seller to reduce the cash price of goods or services purchased in a credit sale transaction. A deferred portion of a downpayment may be treated as part of the downpayment if it is payable not later than the due date of the second otherwise regularly scheduled payment and is not subject to a finance charge.

(20) **"Dwelling"** means a residential structure that contains one to four units, whether or not that structure is attached to real property. The term includes an individual condominium unit, cooperative unit, mobile home, and trailer, if it is used as a residence.

(21) **"Open-end credit"** means consumer credit extended by a creditor under a plan in
which -

(A) the creditor reasonably contemplates repeated transactions;

(B) the creditor may impose a finance charge from time to time on an outstanding unpaid balance; and

(C) the amount of credit that may be extended to the consumer during the term of the plan (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

(22) **"Periodic rate"** means a rate of finance charge that is or may be imposed by a creditor on a balance for a day, week, month, or other subdivision of a year.

(23) **"Person"** means a natural person or an organization, including a corporation, partnership, proprietorship, association, cooperative, estate, trust, or government unit.

(24) **"Prepaid finance charge"** means any finance charge paid separately in cash or by check before or at consummation of a transaction, or withheld from the proceeds of the credit at any time.

(25) **"Residential mortgage transaction"** means a transaction in which a mortgage, deed of trust, purchase money security interest arising under an installment sales contract, or equivalent consensual security interest is created or retained in the consumer's principal dwelling to finance the acquisition or initial construction of that dwelling.

(26) **"Security interest"** means an interest in property that secures performance of a consumer credit obligation and that is recognized by state or federal law. It does not include incidental interests such as interests in proceeds, accessions, additions, fixtures, insurance proceeds (whether or not the creditor is a loss payee or beneficiary), premium rebates, or interests in after-acquired property. For purposes of disclosure under 160:45-3-4 and 160:45-5-2, the term does not include an interest that arises solely by operation of law. However, for purposes of the right of rescission under 160:45-3-13 and 160:45-5-7, the term does include interests that arise solely by operation of law.

(27) **"State"** means any state, the District of Columbia, the Commonwealth of Puerto Rico, and any territory or possession of the United States.

(b) Rules of construction. For purposes of this chapter, the following rules of construction apply:

(1) Where appropriate, the singular form of a word includes the plural form and plural includes singular.

(2) Where the words "obligation" and "transaction" are used in this chapter, they refer to a consumer credit obligation or transaction, depending upon the context. Where the word "credit" is used in this chapter, it means "consumer credit" unless the context clearly indicates otherwise.

(3) Unless defined in this chapter, the words used have the meanings given to them by state law or contract.

(4) Footnotes have the same legal effect as the text of the chapter.

(5) Where the word "amount" is used in this chapter to describe disclosure requirements, it refers to a numerical number.

**160:45-1-3. Exempt transactions**

This chapter does not apply to the following: 4/

(1) **Business, commercial, agricultural or organizational credit.**

(A) An extension of credit primarily for a business, commercial or agricultural purpose.

(B) An extension of credit to other that a natural person, including credit to government agencies or instrumentalities.

(2) ~~**Credit over $45,000 not secured by real property or a dwelling.** An extension of credit not secured by real property, or by personal property used or expected to be used as the principal dwelling of the consumer, in which the amount financed exceeds $45,000 or in which there is an express written commitment to extend credit in excess of $45,000.~~ **Credit over $50,000.00 or applicable threshold amount.**

(A) An extension of credit in which the amount of credit extended exceeds $50,000.00 or in which there is an express written commitment to extend credit in excess of $50,000.00, unless the extension of credit is:

(i) Secured by any real property or by personal property used or expected to be used as the principal dwelling of the consumer; or

(i) A private education loan as defined in the Federal Consumer Credit Protection Act.

(B) The dollar amount in this paragraph is adjusted annually as indicated by the Consumer Financial Protection Bureau to reflect increases in the Consumer Price Index for Urban Wage Earners and Clerical Workers, as applicable.

(3) **Public utility credit.** An extension of credit that involves public utility services provided through pipe, wire, other connected facilities, or radio or similar transmission (including extensions of such facilities), if the charges for service, delayed payment, or any discounts for prompt payment are filed with or regulated by any government unit. The financing of durable goods or home improvements by a public utility is not exempt.

(4) **Securities or commodities accounts.** Transaction in securities or commodities accounts in which credit is extended by a broker-dealer registered with the Securities and Exchange Commission or the Commodity Futures Trading Commission.

(5) **Home fuel budget plans.** An installment agreement for the purchase of home fuels in which no finance charge is imposed.

(6) **Pawnbrokers.** An extension of credit by a pawnbroker engaging in pawn transactions as defined in the Oklahoma Pawnshop Act beginning at §1501 of Title 59 of the Oklahoma Statutes.

(7) **Student loan programs.** Loans made, insured, or guaranteed pursuant to a program authorized by Title IV of the Higher Education Act of 1965 (20 USC 1070 et seq.) or comparable Oklahoma law.

4/ Reserved

## SUBCHAPTER 5. CLOSED-END CREDIT

### 160:45-5-1. General disclosure requirements

(a) **Form of disclosures.**

(1) The creditor shall make the disclosures required by this subchapter clearly and conspicuously in writing, in a form that the consumer may keep. The disclosures required by this subchapter may be provided to the consumer in electronic form, subject to compliance with the consumer consent and other applicable provisions of the Electronic Signatures in Global and National Commerce Act (E-Sign Act) (15 U.S.C. § 7001 et seq.). The disclosures required by 160:45-5-1(g), 160:45-5-3(b), and 160:45-5-8 may be provided to the consumer in electronic form without regard to the consumer consent or other provisions of the E-Sign Act in the circumstances set forth in those sections. The disclosures shall be grouped together, shall be segregated from everything else, and shall not contain any information not directly related 37/ to the disclosures required under 160:45-5-2. 38/ The itemization of the amount financed under 160:45-5-2(3)(A) must be separate from the other disclosures under 160:45-5-2.

(2) The terms "finance charge" and "annual percentage rate," when required to be disclosed under 160:45-5-2(4) and (5) together with a corresponding amount or percentage rate, shall be more conspicuous than any other disclosure, except the creditor's identity under 160:45-5-2(1).

(b) **Time of disclosures.** The creditor shall make disclosures before consummation of the transaction. In certain mortgage transactions, special timing requirements are set forth in 160:45-5-3(a). In certain variable-rate transactions, special timing requirements for variable-rate disclosures are set forth in 160:45-5-3(b) and 160:45-5-4(c). In certain transactions involving mail or telephone orders or a series of sales, the timing of the disclosures may be delayed in accordance with paragraphs (g) and (h) of this section.

(c) **Basis of disclosures and use of estimates.**

(1) The disclosures shall reflect the terms of the legal obligation between the parties.

(2) **Estimates and per-diem interest.**

(A) If any information necessary for an accurate disclosure is unknown to the creditor, the creditor shall make the disclosure based on the best information reasonably available at the time the disclosure is provided to the consumer, and shall state clearly that the disclosure is an estimate.

(B) For a transaction in which a portion of the interest is determined on a per-diem basis and collected at consummation, any disclosure affected by the per-diem interest shall be considered accurate if the disclosure is based on the information known to the creditor at the time that the disclosure documents are prepared for consummation of the transaction.

(3) The creditor may disregard the effects of the following in making calculations and disclosures.

(A) That payments must be collected in whole cents.

(B) That dates of scheduled payments and advances may be changed because the scheduled date is not a business day.

(C) That months have different numbers of days.

(D) The occurrence of leap year.

(4) In making calculations and disclosures, the creditor may disregard any irregularity in the first period that falls within the limits described below and any payment schedule irregularity that results from the irregular first period:

(A) For transactions in which the term is less than 1 year, a first period not more than 6 days shorter or 13 days longer than a regular period;

(B) For transactions in which the term is at least 1 year and less than 10 years, a first period not more than 11 days shorter or 21 days longer than a regular period; and

(C) For transactions in which the term is at least 10 years, a first period shorter than or not more than 32 days longer than a regular period.

(5) If an obligation is payable on demand, the creditor shall make the disclosures based on an assumed maturity of 1 year. If an alternate maturity date is stated in the legal obligation between the parties, the disclosures shall be based on that date.

(6) **Multiple advances.**

(A) A series of advances under an agreement to extend credit up to a certain amount may be considered as one transaction.

(B) When a multiple-advance loan to finance the construction of a dwelling may be permanently financed by the same creditor, the construction phase and the permanent phase may be treated as either one transaction or more than one transaction.

(d) **Multiple creditors; multiple consumers.** If a transaction involves more than one creditor, only one set of disclosures shall be given and the creditors shall agree among themselves which creditor must comply with the requirements that this chapter imposes on any or all of them. If there is more than one consumer, the disclosures may be made to any consumer who is primarily liable on the obligation. If the transaction is rescindable under 160:45-5-7, however, the disclosures shall be made to each consumer who has the right to rescind.

(e) **Effect of subsequent events.** If a disclosure becomes inaccurate because of an event that occurs after the creditor delivers the required disclosures, the inaccuracy is not a violation of this chapter although new disclosures may be required under paragraph (f) of this section, 160:45-5-3, or 160:45-5-4.

(f) **Early disclosures.** If disclosures required by this subchapter are given before the date of consummation of a transaction and a subsequent event makes them inaccurate, the creditor shall disclose before consummation ~~(except that, for certain mortgage transactions, 160:45-5-3(a)(2) permits redisclosure no later than consummation or settlement, whichever is later).~~ (subject to the provisions of 160:45-5-3 ; 39/

(1) Any changed term unless the term was based on an estimate in accordance with 160:45-5-1(c)(2) and was labeled an estimate;

(2) All changed terms, if the annual percentage rate at the time of consummation varies from the annual percentage rate disclosed earlier by more than 1/8 of 1 percentage point in a regular transaction, or more than $\frac{1}{4}$ of 1 percentage point in an irregular transaction, as defined in 160:45-5-6(a).

(g) **Mail or telephone orders - delay in disclosures.** If a creditor receives a purchase order or a request for an extension of credit by mail, telephone, or facsimile machine without face-to-face or direct telephone solicitation, the creditor may delay the disclosures until the due date of the first payment, if the following information for representative amounts or ranges of credit is made available in written form or in electronic form to the consumer or to the public before the actual purchase order or request:

(1) The cash price or the principal loan amount.

(2) The total sale price.

(3) The finance charge.

(4) The annual percentage rate, and if the rate may increase after consummation, the following disclosures:

(A) The circumstances under which the rate may increase.

(B) Any limitations on the increase.

(C) The effect of an increase.

(5) The terms of repayment.

(h) **Series of sales - delay in disclosures.** If a credit sale is one of a series made under an agreement providing that subsequent sales may be added to an outstanding balance, the creditor may delay the required disclosures until the due date of the first payment for the current sale, if the following two conditions are met:

(1) The consumer has approved in writing the annual percentage rate or rates, the range of balances to which they apply, and the method of treating any unearned finance charge on an existing balance.

(2) The creditor retains no security interest in any property after the creditor has received payments equal to the cash price and any finance charge attributable to the sale of that property. For purposes of this provision, in the case of items purchased on different dates, the first purchased is deemed the first item paid for; in the case of items purchased on the same date, the lowest priced is deemed the first item paid for.

(i) **Interim student credit extensions.** For each transaction involving an interim credit extension under a student credit program, the creditor need not make the following disclosures: the finance charge under 160:45-5-2(4), the payment schedule under 160:45-5-2(7), the total of payments under 160:45-5-2(8), or the total sale price under 160:45-5-2(10).

**37/** The disclosures may include an acknowledgment of receipt, the date of the transaction, and the consumer's name, address, and account number.

**38/** The following disclosures may be made together with or separately from other required disclosures: the creditor's identity under 160:45-5-2(1), the variable-rate example under 160:45-5-2(6)(A)(iv), insurance or debt cancellation under 160:45-5-2(14), and under certain security interest-charges under 160:45-5-2(15).

**39/** For certain residential mortgage transactions, 160:45-5-3(a)(2) permits redisclosure no later than consummation or settlement, whichever is later.

**160:45-5-3. Certain mortgage and variable-rate transactions**

(a) **Mortgage transactions subject to RESPA.**

(1) **Time of disclosures.**

(A) In a mortgage transaction subject to the Real Estate Settlement Procedures Act (12 USC 2601 et seq.) that is secured by the consumer's ~~principal~~ dwelling, other than a home equity line of credit subject to 160:45-3-3 or mortgage transaction subject to paragraph (a)(5) of this section, the creditor shall make good faith estimates of the disclosures required by 160:45-5-2 ~~before consummation, or~~ and shall deliver or place them in the mail not later than ~~three business days~~the third business day after the creditor receives the consumer's written application~~, whichever is earlier~~.

(B) **Imposition of fees.** Except as provided in paragraph (a)(1)(~~iii~~)(C) of this section, neither a creditor nor any other person may impose a fee on the consumer in connection with the consumer's application for a mortgage transaction subject to paragraph (a)(1)(~~i)~~ (A) of this section before the consumer has received the disclosures required by paragraph (a)(1)(~~i)~~(A) of this section. If the disclosures are mailed to the consumer, the consumer is considered to have received them three business days after they are mailed.

(C) **Exception to fee restriction.** A creditor or other person may impose a fee for obtaining the consumer's credit history before the consumer has received the disclosures required by paragraph (a)(1)~~(i)~~(A) of this section, provided the fee is bona fide and reasonable in amount.

(2) ~~**Redisclosure required.** If the annual percentage rate at the time of consummation varies from the annual percentage rate disclosed earlier by more than 1/8 of 1 percentage point in a regular transaction or more than 1/4 of 1 percentage point in an irregular transaction, as defined in 160:45-5-6, the creditor shall disclose all the changed terms no later than consummation or settlement.~~ **Waiting periods for early disclosures and corrected disclosures.**

(A) The creditor shall deliver or place in the mail the good faith estimates required by paragraph (a)(1)(A) of this section not later than the seventh business day before consummation of the transaction.

(B) If the annual percentage rate disclosed under paragraph (a)(1)(A) of this section becomes inaccurate, as defined in 160:45-5-6, the creditor shall provide corrected disclosures with all changed terms. The consumer must receive the corrected disclosures no later than three business days before consummation. If the corrected disclosures are mailed to the consumer or delivered to the consumer by means other than delivery in person, the consumer is deemed to have received the corrected disclosures three business days after they are mailed or delivered.

(3) **Consumer's waiver of waiting period before consummation.** If the consumer determines that the extension of credit is needed to meet a bona fide personal financial emergency, the consumer may modify or waive the seven-business-day waiting period or the three-business-day waiting period required by paragraph (a)(2) of this section, after receiving the disclosures required by 160:45-5-2. To modify or waive a waiting period, the consumer shall give the creditor a dated written statement that describes the emergency, specifically modifies or waives the waiting period, and bears the signature of all the consumers who are primarily liable on the legal obligation. Printed forms for this purpose are prohibited.

(4) **Notice.** Disclosures made pursuant to paragraph (a)(1) or paragraph (a)(2) of this section shall contain the following statement: "You are not required to complete this agreement merely because you have received these disclosures or signed a loan application." The disclosure required by this paragraph shall be grouped together with the disclosures required by paragraphs (a)(1) or (a)(2) of this section.

(5) **Timeshare plans.** In a mortgage transaction subject to the Real Estate Settlement Procedures Act (12 USC 2601 et seq.) that is secured by a consumer's interest in a timeshare plan described in 11 USC 101(53(D)):

(A) The requirements of paragraphs (a)(1) through (a)(4) of this section do not apply.

(B) The creditor shall make good faith estimates of the disclosures required by 160:45-5-2 before consummation, or shall deliver or place them in the mail not later than three business days after the creditor receives the consumer's written application, whichever is earlier.

(C) If the annual percentage rate at the time of consummation varies from the annual percentage rate disclosed under paragraph (a)(5)(B) of this section by more than 1/8 of 1 percentage point in a regular transaction or more than 1/4 of 1 percentage point in an irregular transaction, as defined in 160:45-5-6, the creditor shall disclose all the changed terms no later than consummation or settlement.

(b) **Certain variable-rate transactions. 45a/** If the annual percentage rate may increase after consummation in a transaction secured by the consumer's principal dwelling with a term greater than one year, the following disclosures must be provided at the time an application form is provided or before the consumer pays a nonrefundable fee, whichever is earlier: **45b/**

(1) The booklet titled **Consumer Handbook on Adjustable Rate Mortgages** published by the Board and the Federal Home Loan Bank Board, or a suitable substitute.

(2) A loan program disclosure for each variable-rate program in which the consumer expresses an interest. The following disclosures, as applicable, shall be provided:

(A) The fact that the interest rate, payment, or term of the loan can change.

(B) The index or formula used in making adjustments, and a source of information about the index or formula.
(C) An explanation of how the interest rate and payment will be determined, including an explanation of how the index is adjusted, such as by the addition of a margin.
(D) A statement that the consumer should ask about the current margin value and current interest rate.
(E) The fact that the interest rate will be discounted, and a statement that the consumer should ask about the amount of the interest-rate discount.
(F) The frequency of interest-rate and payment changes.
(G) Any rules relating to changes in the index, interest rate, payment amount, and outstanding loan balance including, for example, an explanation of interest-rate or payment limitations, negative amortization, and the interest-rate carryover.
(H) At the option of the creditor, either of the following:
(i) A historical example, based on a $10,000 loan amount, illustrating how payments and the loan balance would have been affected by interest-rate changes implemented according to the terms of the loan-program disclosure. The example shall reflect all significant loan-program terms, such as negative amortization, interest-rate carryover, interest-rate discounts, and interest-rate and payment limitations, that would have been affected by the index movement during the period.
(ii) The maximum interest rate and payment for a $10,000 loan originated at the initial interest rate (index value plus margin, adjusted by the amount of any discount or premium) in effect as of an identified month and year for the loan-program disclosure assuming the maximum periodic increases in rates and payments under the program; and the initial interest rate and payment for that loan and a statement that the periodic payment may increase or decrease substantially depending on changes in the rate.
(I) An explanation of how the consumer may calculate the payments for the loan amount to be borrowed based on either -
(i) the most recent payment shown in the historical example in paragraph (b)(2)(H)(i) of this section; or
(ii) the initial interest rate used to calculate the maximum interest rate and payment in paragraph (b)(2)(H)(ii) of this section.
(J) The fact that the loan program contains a demand feature.
(K) The type of information that will be provided in notices of adjustments and the timing of such notices.
(L) A statement that disclosure forms are available for the creditor's other variable-rate loan programs.

(c) **Electronic disclosures.** For an application that is accessed by the consumer in electronic form, the disclosures required by paragraph (b) of this section may be provided to the consumer in electronic form on or with the application.
**45a/** Information provided in accordance with variable-rate regulations of federal agencies may be substituted for the disclosures required by paragraph (b) of this section.
**45b/** Disclosures may be delivered or placed in the mail not later than three business days following receipt of a consumer's application when the application reaches the creditor by telephone, or through an intermediary agent or broker.

**160:45-5-9. Mortgage transfer disclosures**
(a) **Scope.** The disclosure requirements of this section apply to any covered person except as otherwise provided in this section. For purposes of this section:
(1) **"Covered person"** means any person, as defined in 160:45-1-2(a)(23), that becomes the owner of an existing mortgage loan by acquiring legal title to the debt obligation, whether through a purchase, assignment, or other transfer, and who acquires more than one mortgage loan in any twelve-month period. For purposes of this section, a servicer of a mortgage loan shall not be treated as the owner of the obligation if the servicer holds title to the loan or title is assigned to the servicer, solely for the administrative convenience of the servicer in servicing the obligation.
(2) **"Mortgage loan"** means any consumer credit transaction that is secured by the principal dwelling of a consumer.
(b) **Disclosure required.** Except as provided in paragraph (c) of this section, each covered person is subject to the requirements of this section and shall mail or deliver the disclosures required by this section to the consumer on or before the 30th calendar day following the date of transfer.
(1) **Form of disclosures.** The disclosures required by this section shall be provided clearly and conspicuously in writing, in a form that the consumer may keep. The disclosures required by this section may be provided to the consumer in electronic form, subject to compliance with the consumer consent and other applicable provisions of the Electronic Signatures in Global and National Commerce Act (E-Sign Act) (15 U.S.C. 7001 et seq.).
(2) **The date of transfer.** For purposes of this section, the date of transfer to the covered person may, at the option of the covered person, be either the date of acquisition recognized in the books and records of the acquiring party, or the date of transfer recognized in the books and records of the transferring party.
(3) **Multiple consumers.** If more than one consumer is liable on the obligation, a covered person may mail or deliver the disclosures to any consumer who is primarily liable.
(4) **Multiple transfers.** If a mortgage loan is acquired by a covered person and subsequently sold, assigned, or otherwise transferred to another covered person, a single

disclosure may be provided on behalf of both covered persons if the disclosure satisfies the timing and content requirements applicable to each covered person.

(5) **Multiple covered persons.** If an acquisition involves multiple covered persons who jointly acquire the loan, a single disclosure must be provided on behalf of all covered persons.

(c) **Exceptions.** Notwithstanding paragraph (b) of this section, a covered person is not subject to the requirements of this section with respect to a particular mortgage loan if:

(1) The covered person sells or otherwise transfers or assigns legal title to the mortgage loan on or before the 30th calendar day following the date that the covered person acquired the mortgage loan which shall be the date of transfer recognized for purposes of paragraph (b)(2);

(2) The mortgage loan is transferred to the covered person in connection with a repurchase agreement that obligates the transferor to repurchase the loan. However, if the transferor does not repurchase the loan, the covered person must provide the disclosures required by this section within 30 days after the date that the transaction is recognized as an acquisition on its books and records; or

(3) The covered person acquires only a partial interest in the loan and the party authorized to receive the consumer's notice of the right to rescind and resolve issues concerning the consumer's payments on the loan does not change as a result of the transfer of the partial.

(d) **Content of required disclosures.** The disclosures required by this section shall identify the loan that was acquired or transferred and state the following:

(1) The name, address, and telephone number of the covered person.

(i) If a single disclosure is provided on behalf of more than one covered person, the information required by this paragraph shall be provided for each of them unless paragraph (d)(1)(ii) of this section applies.

(ii) If a single disclosure is provided on behalf of more than one covered person and one of them has been authorized in accordance with paragraph (d)(3) of this section to receive the consumer's notice of the right to rescind and resolve issues concerning the consumer's payments on the loan, the information required by paragraph (d)(1) of this section may be provided only for that covered person.

(2) The date of transfer.

(3) The name, address and telephone number of an agent or party authorized to receive notice of the right to rescind and resolve issues concerning the consumer's payments on the loan. However, no information is required to be provided under this paragraph if the consumer can use the information provided under paragraph (d)(1) Of this section for these purposes.

(4) Where transfer of ownership of the debt to the covered person is or may be recorded in public records, or alternatively, that the transfer of ownership has not been recorded in public records at the time the disclosure is provided.

(e) **Optional disclosures.** In addition to the information required to be disclosed under paragraph (d) of this section, a covered person may, at its option, provide any other information regarding the transaction.

*[OAR Docket #13-899; filed 5-23-13]*

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## TITLE 165. CORPORATION COMMISSION
## CHAPTER 5. RULES OF PRACTICE

*[OAR Docket #13-910]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Fees
Part 3. Public Utility Assessment Fees
165:5-3-21. Definitions [AMENDED]
165:5-3-22. Fee allocation [AMENDED]
165:5-3-25. Reporting requirement [AMENDED]
Subchapter 7. Commencement of a Cause
Part 3. Oil and Gas
165:5-7-6. Drilling and spacing unit establishment or modification [AMENDED]
165:5-7-27. Enhancement or addition of injection and disposal wells [AMENDED]
Subchapter 23. Informal Resolution of Natural Gas Gathering Disputes
165:5-23-6. Helpline ~~and Conservation Division report~~ [AMENDED]
Appendix F. Notice of Application for Authority Authorizing Commercial Pit/Soil Farming [REVOKED]
Appendix F. Notice of Application for Authority Authorizing Commercial Pit/Soil Farming/Recycling Facility [NEW]
**AUTHORITY:**
Oklahoma Corporation Commission; 17 O.S. § 52, 17 O.S. § 139.101 *et seq.*, 17 O.S. § 180.11, 27A O.S. § 1-3-101, 52 O.S. § 139, Article IX, Section 18 of the Oklahoma Constitution and OAC 165:5-1-7
**DATES:**
**Comment period:**
January 8, 2013, through February 27, 2013
**Public hearing:**
March 12, 2013
**Adoption:**
March 12, 2013
**Submitted to Governor:**
March 19, 2013
**Submitted to House:**
March 19, 2013
**Submitted to Senate:**
March 19, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 16, 2013.
**Final adoption:**
May 16, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
OAC 165:5-3-21 is amended to correct a typographical error and to add language clarifying what the regulated Oklahoma jurisdictional annual gross operating revenues shall include for telecommunications companies; OAC 165:5-3-22 to add language which allows notice of the annual assessed amount pursuant to 17 O.S. § 180.11 to be sent by electronic mail to public

utilities; OAC 165:5-3-25 to correct a typographical error, and OAC 165:5-7-6 to include information which needs to appear in applications and orders pertaining to proceedings to establish or form horizontal well units, and what types of evidence and testimony need to be presented to establish good cause for obtaining a waiver of the consent requirement so as to effectuate Commission orders authorizing horizontal well units that overlie existing wells or existing drilling and spacing units producing from the same common source of supply.

OAC 165:5-7-27 is amended concerning notice for proposed noncommercial injection or disposal wells and commercial disposal wells, and surety requirements for commercial disposal well facilities; OAC 165:5-23-6 to delete the requirement that the Conservation Division maintain and circulate an internal report of filed Notices of Intent to Mediate regarding informal resolution of natural gas gathering disputes, and revoke Appendix F and add a new Appendix F to correspond to requirements appearing in OAC 165:5-7-35 regarding notices of applications for authority to operate commercial pits, commercial soil farming sites and/or commercial recycling facilities.

**CONTACT PERSON:**

Susan Dennehy Conrad, Deputy General Counsel, Office of General Counsel, Oklahoma Corporation Commission, 2101 North Lincoln Boulevard, PO Box 52000, Oklahoma City, OK 73152-2000, telephone: (405) 521-3939.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. FEES

## PART 3. PUBLIC UTILITY ASSESSMENT FEES

### 165:5-3-21. Definitions

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

**"Director"** means the Director of the Public Utility Division of the Oklahoma Corporation Commission.

**"Filing tariffs with the Commission"** means submission of the tariffs to the Director.

**"Fiscal year"** means the period beginning July 1 and ending June 30 of each year.

**"Public utility"** means:

(A) Those companies as defined by 17 Okl.St.Ann. 151, excluding those companies encompassed by paragraph (d) of Section 151.

(B) Any telephone or telecommunications company subject to 17 Okl.St.Ann. §131 et seq., including interexchange telecommunications companies as defined by ~~165:55-1-47~~165:55-1-4, resellers as defined by 165:56, and operator service providers as defined by 165:57, and pay phone service providers as defined by 165:58.

(C) Any association or cooperative corporation doing business under the Rural Electric Cooperative Act except for generation and transmission associations or cooperative corporations, or transmission associations or cooperative corporations.

**"Regulated Oklahoma jurisdictional annual gross operating revenues"** means those revenues which are recorded in the accounts of the public utility, resulting from sales of commodities or services provided to regulated Oklahoma jurisdictional customers. For telecommunications companies this shall include, but should not be limited to, support received for intrastate services from all Oklahoma and Federal universal service and low income funds.

**"Regulated Oklahoma Jurisdictional Customers"** means any person, member of a cooperative, firm, corporation, municipality or agency, other political subdivision, or the United States or the State of Oklahoma, receiving utility service from a public utility pursuant to rates and charges established by, or filed with the Commission.

### 165:5-3-22. Fee allocation

(a) Pursuant to 17 Okla.St.Ann. 1993, §180.11, an annual fee shall be assessed as follows:

(1) The assessment shall, after excluding the amount allocated to the interexchange telecommunications companies, resellers, pay phone service providers and operator service providers in paragraph (2) of this subsection, be borne by the affected public utilities as follows:

(A) One-half shall be allocated based on that proportion which the total regulated Oklahoma jurisdictional gross operating revenues of each public utility bears to the total regulated Oklahoma jurisdictional gross operating revenues of all public utilities; which amounts shall be exclusive of amounts paid to public utilities pursuant to rates and charges established by the Commission if the public utility provides response to 165:5-3-25(a)(3), and

(B) One-half shall be allocated based on that proportion which the total number of regulated Oklahoma jurisdictional customers of each public utility bears to the total number of regulated Oklahoma jurisdictional customers of all public utilities.

(2) For interexchange telecommunications companies, resellers, pay phone service providers and operator service providers, the allocation shall be based on the proportion that each interexchange telecommunications company's total regulated Oklahoma jurisdictional gross operating revenues bears to the total regulated Oklahoma jurisdictional gross operating revenues of all public utilities; which amounts shall be exclusive of amounts paid to public utilities pursuant to rates and charges established by the Commission if the public utility provides response to 165:5-3-25(a)(3) as applied to the total amount of the assessment to be collected from all public utilities for each year.

(b) The fees assessed pursuant to this Section shall be on a fiscal year basis and shall equal the amount of the budgetary limit for the Public Utility Division established by the legislature for said fiscal year.

(c) After final legislative and gubernatorial approval of the budgetary limit for the Public Utility Division, notice of the annual assessed amount pursuant to (a)(1) and (2) of this Section shall be sent by electronic mail or certified mail, return receipt requested, to each public utility.

**165:5-3-25. Reporting requirement**

(a) On or before May 15 of each year, each affected public utility shall submit to the Director a report based on the ~~preceding~~preceding calendar year containing the following data:

(1) Monthly average regulated Oklahoma jurisdictional customers.

(2) Total regulated Oklahoma jurisdictional gross operating revenues.

(3) Total amounts paid to other public utilities pursuant to rates and charges established by the Commission.

(b) The reporting requirement set forth in (a)(1) of this Section does not apply to interexchange telecommunication companies.

(c) The reporting requirement set forth in (a)(3) of this Section is optional.

## SUBCHAPTER 7. COMMENCEMENT OF A CAUSE

## PART 3. OIL AND GAS

**165:5-7-6. Drilling and spacing unit establishment or modification**

(a) Notice of hearing relating to drilling and spacing units shall be published one time at least fifteen (15) days prior to the hearing in a newspaper of general circulation published in Oklahoma County, Oklahoma, and in a newspaper of general circulation published in each county in which lands embraced in the application are located.

(b) When an applicant proposes to establish, vacate, alter, modify, amend, or extend a drilling and spacing unit, the application and notice shall be served by the applicant no less than fifteen (15) days prior to the date of the hearing, by regular mail, upon each person or governmental entity having the right to participate in production from the proposed drilling and spacing unit or the existing drilling and spacing unit.

(c) A plat or plats shall be attached to each application for an order to establish a drilling and spacing unit or units or to extend existing spacing within a common source or sources of supply, which plat shall show the spacing units requested together with any spacing units abutting or overlapping the area to be spaced, and any abutting spacing units in all spaced formations. An amended plat shall be provided at the time of the hearing in the event drilling and spacing units have been established after the application was filed and prior to the hearing to reflect the status of the spacing at the time of the hearing.

(d) An application to extend spacing from an adjacent drilling and spacing unit shall state in the body of the application the most recent order number that created the spacing in the adjacent unit that applies to the common sources of supply which are sought to be extended by the application. Such request to extend spacing and citation to the most recent order number shall be placed in the special relief paragraph of the notice of hearing.

(e) Where a well has not been commenced to or completed in the common source of supply sought to be spaced, notice of hearing for an order to vacate, alter, amend, extend, or change a prior spacing order shall be served and published as required in (a) of this Section. Such request to vacate, alter, amend, extend, or change a prior spacing order shall be placed in the special relief paragraph of the notice of hearing.

(f) Where two or more orders have issued spacing a common source of supply and such spacing orders have resulted in there being a conflict either as to the size of the unit or as to a common source of supply or a conflict as to the nomenclature of the common source of supply, then the applicant seeking to vacate, alter, amend, or change one of the prior spacing orders shall either file an application to construe and modify the conflicting orders or may amend a relevant application to accomplish the same result. Notice of hearing shall be served and published as required upon the commencement of a proceeding.

(g) The Commission may issue an order establishing horizontal well units for a common source of supply. A horizontal well unit may be established for a common source of supply for which there are already established non-horizontal drilling and spacing units, and said horizontal well unit may include within the boundaries thereof more than one existing non-horizontal drilling and spacing unit for the common source of supply. Upon the formation of a horizontal well unit that includes within the boundaries thereof one or more non-horizontal drilling and spacing units, the Commission may provide that such horizontal well unit supersedes one or more of such non-horizontal drilling and spacing units or may provide that such horizontal well unit exists concurrently with one or more of such non-horizontal drilling and spacing units. In the event the Commission provides for the concurrent existence of a horizontal well unit and a non-horizontal drilling and spacing unit, as provided above, each such unit may be concurrently developed.

(1) In any spacing proceeding to establish or form a horizontal well unit, the application filed in such proceeding shall set forth and describe:

(A) any non-horizontal drilling and spacing unit that may be superseded by such horizontal well unit; and

(B) any non-horizontal drilling and spacing unit that may exist concurrently with such horizontal well unit, including the well or wells located in any such non-horizontal drilling and spacing unit.

(2) The order entered in such proceeding shall describe any non-horizontal drilling and spacing unit that will be superseded by the horizontal well unit, and shall describe any non-horizontal drilling and spacing unit that will exist concurrently with the horizontal well unit, including the well or wells located in such non-horizontal drilling and spacing unit. The order establishing or forming a horizontal well unit that will exist concurrently with any non-horizontal drilling and spacing unit shall state, based on the evidence presented, that the consent in writing required by subsection (h) of this Section has been obtained and filed or that a waiver of such consent requirement as authorized by subsection (i) of this Section has been granted by the Commission.

(h) No order of the Commission authorizing a horizontal well unit that overlies any existing well or portion of any existing drilling and spacing unit producing from the same common source of supply will become effective until at least fifty percent (50%) of the ownership having a right to drill in each such well and/or drilling and spacing unit consents in writing to the horizontal well unit by filing such written consent with the Court Clerk of the Commission in such cause. Requests for such consent must be sent by restricted mail to the owners having the right to drill in any existing well and/or drilling and spacing unit producing from the same common source of supply as the proposed horizontal well unit. In addition, if the boundaries of the horizontal well unit do not encompass such existing drilling and spacing unit in its entirety, then the application and notice for the horizontal well unit shall be served by the applicant no less than fifteen (15) days prior to the date of the hearing, by regular mail, upon each person or governmental entity having the right to participate in production from the existing drilling and spacing unit.

(i) Any written consent to the order required under subsection (h) of this Section shall not be a waiver of, nor commitment of, any rights of such owners in either the existing production or the proposed horizontal well unit. If the required percentage of consent cannot be obtained, the applicant may make application to the Commission for a waiver of the consent requirement, and upon a showing of good cause by the applicant, the Commission may waive the consent requirement. For purposes of this subsection, a showing of good cause means applicant must present sufficient testimony and evidence, and the Commission must find in the order, that applicant has established the following:

(1) Due diligence was exercised to locate each owner having a right to drill in any existing well and/or any existing drilling and spacing unit producing from the same common source of supply as the proposed horizontal well unit;

(2) A bona fide effort was made to obtain the required percentage of consent;

(3) Alternate methods of development are inadequate to prevent waste and to protect correlative rights unless the consent requirement is waived and the proposed horizontal well unit created; and

(4) Any correlative rights or vested rights, or both, of owners in the existing well(s) and/or drilling and spacing unit(s), and in the proposed horizontal well unit, will be adequately protected if the consent requirement is waived and the proposed horizontal well unit created.

**165:5-7-27. Enhancement or addition of injection and disposal wells**

(a) Each application for the approval of a newly drilled or newly converted injection well or disposal well shall be filed with the UIC Department on Form 1015 and shall be verified by a duly authorized representative of the operator.

(b) The application for the approval of an enhanced recovery injection or disposal well or wells shall be accompanied by:

(1) Plat.

(A) Noncommercial. A plat showing the location and total depth of the well or wells and each abandoned, producing or drilling well, and dry hole within one-quarter (1/4) mile of the enhanced recovery injection well or disposal well, and identifying the surface owner of the land on which the enhanced recovery injection or disposal well is to be located, and each operator of a producing ~~leasehold~~spacing unit or well within ~~one-quarter (1/4)~~one-half (1/2) mile of each enhanced recovery injection or disposal well with a requested injection rate of less than five thousand barrels per day, and each operator of a producing spacing unit or well within one (1) mile of each enhanced recovery injection or disposal well with a requested injection rate of five thousand barrels per day or more.

(B) Commercial. A plat showing the location and total depth of the well or wells and each abandoned, producing or drilling well and dry hole within one-half (1/2) mile of the disposal well, and identifying the surface owner of the land on which the disposal well is to be located, and each operator of a producing ~~leasehold~~spacing unit or well within ~~one-half (1/2)~~one (1) mile of each disposal well.

(2) If the well has been drilled, a copy of the Completion Report (Form 1002A) and any available electric or radioactivity log of the well.

(3) A schematic diagram of the well showing:

(A) The total depth or plugback depth of the well.

(B) The depth of the injection or disposal interval indicating both the top and bottom.

(C) The geological name of the injection or disposal zone.

(D) The depths of the tops and bottoms of the casing and cement to be used in the well.

(E) The size of the casing and tubing, and the depth of the packer.

(4) Information showing that injection into the proposed zone will not initiate fractures through the overlying strata which could enable the injection fluid or formation fluid to enter fresh water strata.

(A) When the fluid injection rate is 1,000 barrels per day or less, or an equivalent rate for any fraction of twenty-four (24) hours, an overlying strata of at least 200 feet in thickness between the lowest base of fresh water and the top of the proposed interval of injection is considered sufficient evidence of fresh water protection.

(B) When the fluid injection rate is greater than 1,000 barrels per day or an equivalent rate for any fraction of twenty-four (24) hours, an overlying strata of at least 500 feet in thickness between the lowest base of fresh water and the top of the proposed interval of injection is considered sufficient evidence of fresh water protection.

(C) If the overlying strata is less than required in (A) and (B) of this paragraph, the Commission may administratively approve injection provided a finding

is made that such injection will not initiate fractures through the overlying strata into the fresh water strata. Applicant is required to furnish the Commission sworn evidence and data in support of such findings. The Commission, when issuing a permit approving fluid injection, shall consider the following:

(i) Maximum injection rate.

(ii) Maximum surface injection pressure.

(iii) Injection fluid.

(iv) The lithology and rock characteristics of the injection zones and overlying strata.

(5) Proposed operating data:

(A) Daily injection rates and pressures.

(B) Geologic name, depth, and location of injection fluid source.

(C) Qualitative and quantitative analysis of fresh water from two (2) or more fresh water wells within one (1) mile of the proposed enhanced recovery injection or disposal well showing location of wells and dates samples were taken, or statement why samples were not submitted. The analysis shall include at a minimum chloride, sodium, and total dissolved solids.

(D) Qualitative and quantitative analysis of representative sample of water to be injected. The analysis shall include at a minimum chloride, sodium, and total dissolved solids.

(c) A copy of the application for approval of injection or disposal of water or other substances in a well shall be served by the applicant within five (5) days of the date the application is filed by regular mail or delivered to the owner of the surface of the land on which the injection or disposal well is to be located, and with regard to injection or disposal wells with a requested injection rate of less than five thousand barrels per day to each operator of a producing ~~leasehold~~spacing unit or well within one-half (1/2) mile of the proposed noncommercial injection or disposal well location, and to each operator of a producing spacing unit or well within one (1) mile of either a proposed noncommercial injection or disposal well location with a requested injection rate of five thousand barrels per day or more or a proposed commercial disposal well location. In addition, if the application involves a proposed horizontal injection or disposal well, a copy of the application for approval shall be served by the applicant within five (5) days of the date the application is filed by regular mail or delivered to each operator of a producing ~~leasehold~~spacing unit or well within one-half (1/2) mile of the lateral of the proposed noncommercial injection or disposal well with a requested injection rate of less than five thousand barrels per day, and to each operator of a producing spacing unit or well within one (1) mile of the lateral of either a proposed noncommercial injection or disposal well with a requested injection rate of five thousand barrels per day or more or a proposed commercial disposal well. Further, if the application involves a proposed commercial disposal well, a copy of the application for approval shall be served within five (5) days of the date the application is filed by regular mail or delivered to each surface owner and surface lessee of record on each tract of land adjacent and contiguous to the site of the proposed well.

(d) Notice of an application relating to injection, disposal or commercial wells shall be published one time for injection and noncommercial disposal wells and two times for a commercial disposal well in a newspaper of general circulation published in Oklahoma County, Oklahoma, and in a newspaper of general circulation published in each county in which land embraced in the application are located. The notice shall include:

(1) PD or tracking number.

(2) Name and address of applicant.

(3) Location of proposed well to nearest 10 acre tract.

(4) Well name.

(5) The geological name of the injection formation.

(6) The top and bottom of the injection interval.

(7) Maximum injection pressures.

(8) Maximum B/D or MCF/D injection rate.

(9) The type of well (injection, disposal, commercial).

(e) If a written objection to the application is filed within fifteen (15) days after the application is published for injection and noncommercial disposal wells or thirty (30) days after the last publication date for commercial disposal wells, or if hearing is required by the Commission, the application shall be set for hearing and notice thereof shall be given in the same manner as required for the filing of the application. If no objection is filed and the Commission does not require a hearing, the matter may be approved administratively by the Manager of Underground Injection Control.

(f) Any operator of a commercial disposal well facility shall file with the Manager of Document Handling for the Conservation Division an agreement to properly plug the well and reclaim the site upon termination of operations. The agreement shall be on forms available from the Conservation Division and shall be accompanied by surety. The agreement shall provide that if the Commission finds that the operator has failed or refused to comply with Commission rules or take remedial action as required by law and Commission rules, the surety shall pay to the Commission the full amount of the operator's obligation up to the limit of the surety.

(g) The Commission shall establish the amount of surety in the order or permit for the authority to operate a commercial disposal well facility. The amount of surety shall be based on factors such as the depth of the well, dimensions of the facility, and costs of plugging the well, reclamation, monitoring, plugging of monitor wells, any pit closure, trucking of any deleterious substances, remediation and earth work. The amount may be subject to change for good cause. The surety shall be maintained for as long as monitoring is required. The type of surety shall be a corporate surety bond, certificate of deposit, irrevocable commercial letter of credit, or other type of surety approved by order or permit of the Commission. Any type of surety that expires shall be renewed prior to 30 days before the expiration date.

(h) Operators of commercial disposal well facilities authorized prior to the effective date of subsections (f) and (g) must either comply with those subsections or close such facilities within one (1) year of the effective date of those subsections.

(~~f~~i) Optionally, the operator can file a Unit-wide Application for Injection (Form 1015U) that fulfills all the requirements of (b) through (e) of this Section. Upon review and approval, the operator receives a Unit-wide permit that allows the operator to file a traditional, individual well application (Form 1015) and if it fits the Unit-wide criteria, the UIC permit can be issued immediately without additional area of review, notice, or protest period.

## SUBCHAPTER 23. INFORMAL RESOLUTION OF NATURAL GAS GATHERING DISPUTES

**165:5-23-6. Helpline ~~and Conservation Division report~~**

~~(a)~~ Prior to filing a Formal Complaint, parties complaining about natural gas gathering services may register such complaints with the Conservation Division using the Commission Gas Gathering Helpline. Conservation Division staff shall answer calls to the Helpline from 8:00 a.m. to 4:30 p.m. on all regular Commission business days. The Helpline shall record the information sought in OAC 165:5-23-3(a) of this Subchapter, shall instruct the caller that a Notice of Intent to Mediate containingthe same information must be filed to commence the informal dispute resolution procedure and that the Notice of Intent to Mediate and any attachments must be served by registered mail, facsimile or personal delivery on the Respondent, and shall inform the caller that there is no filing fee charged for a Notice of Intent to Mediate, but a $5.00 fee per participant will be charged for any informal dispute resolution procedure that is commenced. Any Complainant calling the Helpline will be referred to appropriate Conservation Division staff for further information. The Helpline shall neither record nor act upon any anonymous complaints under this subsection.

~~The Conservation Division shall maintain an internal report of all Notices of Intent to Mediate filed. The report shall be circulated no less often than once every six months to the Commissioners, the Director of the Conservation Division, the General Counsel and the Director of Administrative Proceedings. The internal report shall include only the following information:~~

~~(1) The case number, if applicable;~~

~~(2) The Participants' names;~~

~~(3) The county to which the disputed gas gathering service pertains;~~

~~(4) The date the Notice of Intent to Mediate was received by the Commission;~~

~~(5) A brief description of the dispute;~~

~~(6) The procedural status of the dispute; and~~

~~(7) A tabulation of pending and resolved disputes.~~

## APPENDIX F. NOTICE OF APPLICATION FOR AUTHORITY AUTHORIZING COMMERCIAL PIT/SOIL FARMING [REVOKED]

## APPENDIX F. NOTICE OF APPLICATION FOR AUTHORITY AUTHORIZING COMMERCIAL PIT/SOIL FARMING/RECYCLING FACILITY [NEW]

BEFORE THE CORPORATION COMMISSION OF THE STATE OF OKLAHOMA

| | | |
|---|---|---|
| APPLICANT: | ) | |
| | ) | |
| RELIEF SOUGHT: ORDER AUTHORIZING | ) | |
| COMMERCIAL PIT(S), COMMERCIAL | ) | CAUSE PD NO. _____ |
| SOIL FARMING SITE AND/OR | ) | |
| COMMERCIAL RECYCLING FACILITY | ) | |
| (as appropriate) | ) | |
| | ) | |
| LEGAL DESCRIPTION(S): | ) | |
| (LIST LOCATION OF PROPOSED | ) | |
| SITE(S) TO NEAREST 10 ACRE TRACT) | ) | |

NOTICE OF APPLICATION FOR AUTHORITY TO OPERATE COMMERCIAL PIT(S), COMMERCIAL SOIL FARMING SITE AND/OR COMMERCIAL RECYCLING FACILITY

NOTICE IS HEREBY GIVEN that the Applicant in this cause is requesting the Commission to issue an order granting the Applicant authority to operate a commercial pit(s), a commercial soil farming site and/or a commercial recycling facility (as appropriate) at the above-captioned location(s).

NOTICE IS ALSO GIVEN that any protest to this application must be filed with the Court Clerk within the protest period prescribed by 165:5-7-35, said protest period being not less than thirty (30) days after publication of this notice.

NOTICE IS FURTHER GIVEN that an initial site inspection shall be made by the Applicant and the Pollution Abatement staff on the ____ day of _____, 20__. Any interested person may attend.

NOTICE IS FURTHER GIVEN that if the application is unprotested then it shall be referred to the Conservation Division of the Commission for review without hearing and that if the application is protested, then any protestants shall receive notice of hearing as prescribed by 165:5-7-35.

_____
Chairman

_____
Vice Chairman

_____
Commissioner

DONE AND PERFORMED this ___ day of _____, 20__.

BY ORDER OF THE COMMISSION:

_____
Secretary of the Commission

*[OAR Docket #13-910; filed 5-24-13]*

# TITLE 165. CORPORATION COMMISSION
# CHAPTER 10. OIL & GAS CONSERVATION

*[OAR Docket #13-911]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. Administration
Part 1. General Provisions
165:10-1-4. Citation effective date [AMENDED]
165:10-1-7. Prescribed forms [AMENDED]
Subchapter 3. Drilling, Developing, and Producing
Part 1. Drilling
165:10-3-3. ~~Surface and production casing~~Well casing strings [AMENDED]
165:10-3-4. Casing, cementing, wellhead equipment, and cementing reports [AMENDED]
Part 3. Completions
165:10-3-17. Well site and surface facilities [AMENDED]
Part 5. Operations
165:10-3-28. Horizontal drilling [AMENDED]
Subchapter 5. Underground Injection Control
165:10-5-5. Application for approval of enhanced recovery injection and disposal operations [AMENDED]
165:10-5-6. Testing and monitoring requirements for enhanced recovery injection wells and disposal wells [AMENDED]
165:10-5-7. Monitoring and reporting requirements for wells covered by 165:10-5-1 [AMENDED]
Subchapter 7. Pollution Abatement
Part 1. General Provisions
165:10-7-10. Registration for land application of deleterious substances [NEW]
Part 3. Storage and Disposal of Fluids
165:10-7-16. Use of noncommercial pits [AMENDED]
165:10-7-17. Surface discharge of fluids [AMENDED]
165:10-7-19. ~~One-time land~~Land application of water-based fluids from earthen pits~~, and~~ tanks and pipeline construction [AMENDED]
165:10-7-24. Waste management practices reference chart [AMENDED]
165:10-7-26. ~~One-time land~~Land application of contaminated soils and petroleum hydrocarbon based drill cuttings [AMENDED]
165:10-7-31. Seismic and stratigraphic operations [AMENDED]
Subchapter 9. Commercial Disposal Facilities
165:10-9-1. Use of commercial pits [AMENDED]
165:10-9-3. Commercial disposal well surface facilities [AMENDED]
Subchapter 11. Plugging and Abandonment
165:10-11-4. Notification and witnessing of plugging [AMENDED]
Subchapter 17. Gas Well Operations and Permitted Production
165:10-17-7. Well tests [AMENDED]
165:10-17-11. Maximum permitted rates of production for unallocated gas wells [AMENDED]
**AUTHORITY:**
Oklahoma Corporation Commission; 17 O.S. §52, 27A O.S. §1-3-101, 52 O.S. §139, 52 O.S. §318.22 and OAC 165:5-1-7
**COMMENT PERIOD:**
January 8, 2013, through February 27, 2013
**PUBLIC HEARING:**
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**ADOPTION:**
March 12, 2013
**SUBMITTED TO GOVERNOR:**
March 19, 2013
**SUBMITTED TO HOUSE:**
March 19, 2013
**SUBMITTED TO SENATE:**
March 19, 2013
**GUBERNATORIAL APPROVAL:**
April 29, 2013
**LEGISLATIVE APPROVAL:**
Failure of the Legislature to disapprove the rules resulted in approval on May 16, 2013.
**FINAL ADOPTION:**
May 16, 2013
**EFFECTIVE:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The amendments to OAC 165:10-7-31 regarding seismic operations were made to conform to amendments to the Seismic Exploration Regulation Act in Senate Bill Nos. 243 and 1665 (2012)(52 O.S. §§ 318.21 through 318.23). OAC 165:10-1-7 and OAC 165:10-7-16 were amended to provide for use of a new Form 1014F regarding flow back water pits with capacities in excess of fifty thousand barrels. Other rules were amended in an effort to update, standardize and streamline language and procedures appearing in OAC 165:10, as well as to address changes in technology, especially with respect to horizontal drilling.
**CONTACT PERSON:**
Susan Dennehy Conrad, Deputy General Counsel, Office of General Counsel, Oklahoma Corporation Commission, 2101 North Lincoln Boulevard, PO Box 52000, Oklahoma City, OK 73152-2000, telephone: (405) 521-3939.

**DUE TO EXCESSIVE LENGTH OF THESE RULES (AS DEFINED IN OAC 655:10-7-12), THE FULL TEXT OF THESE RULES WILL NOT BE PUBLISHED. THE RULES ARE AVAILABLE FOR PUBLIC INSPECTION AT THE OKLAHOMA CORPORATION COMMISSION, WESTERN REGIONAL SERVICE OFFICE, JIM THORPE OFFICE BUILDING, 2101 NORTH LINCOLN BOULEVARD, OKLAHOMA CITY, OKLAHOMA, AT THE OKLAHOMA CORPORATION COMMISSION, EASTERN REGIONAL SERVICE OFFICE, KERR BUILDING, 440 SOUTH HOUSTON, SUITE 114, TULSA, OKLAHOMA, AND AT THE SECRETARY OF STATE'S OFFICE OF ADMINISTRATIVE RULES. THE FOLLOWING SUMMARY HAS BEEN PREPARED PURSUANT TO 75 O.S., SECTION 255(B):**

**SUMMARY:**
OAC 165:10-1-4 is amended to update the list of effective dates for OAC 165:10 rulemakings; OAC 165:10-1-7 to update the list of Corporation Commission Oil and Gas Conservation Division ("OGCD") prescribed forms; OAC 165:10-3-3 to revise notification procedures regarding ruptures, breaks or openings in well casing strings and to increase the fine amount for failure to timely report such incidents; OAC 165:10-3-4 to require operators to give at least forty-eight, rather than twenty-four, hours notice of commencement of hydraulic fracturing operations to the OGCD to satisfy Environmental Protection Agency notification requirements; OAC 165:10-3-17 to require information such as an operator's twenty-four hour emergency telephone number and prohibition of trespassing on lease signs; OAC 165:10-3-28 regarding horizontal well units and non-horizontal drilling and spacing units; OAC 165:10-5-5 concerning notice for proposed noncommercial injection or disposal wells and commercial disposal wells, and surety requirements for commercial disposal well facilities; OAC 165:10-5-6 so as to correct references to certain portions of the rule regarding testing and monitoring requirements for enhanced recovery injection wells and disposal wells; OAC 165:10-5-7 regarding monitoring and reporting requirements for underground injection wells, including requiring operators of commercial disposal wells to submit Form 1012 fluid injection reports to the OGCD on a semiannual rather than quarterly basis, to modify record requirements regarding loads of deleterious substances disposed of at commercial disposal wells and to correct references to portions of the rule, and OAC 165:10-7-10 is a new rule requiring registrations of persons who contract to land apply deleterious substances.

OAC 165:10-7-16 is amended regarding noncommercial pits, including notification to the OGCD prior to testing pit soil liners, use of a new Form 1014F for flow back water pits with capacities in excess of fifty thousand barrels, notice of applications regarding such pits and use of such pits on a temporary basis by another operator; OAC 165:10-7-17 regarding surface discharge of fluids to include references to Form 1014LA pertaining to designation of land application agents; OAC 165:10-7-19 concerning land application of water based fluids, including allowing water based fluids from pipeline construction to be land applied, modifying requirements for land application vehicles, revising time periods for land application and changing post-application report requirements; OAC 165:10-7-24 regarding waste management practices, including listing disposal options for water based mud and cuttings associated with pipeline construction; OAC 165:10-7-26 with respect to land application of contaminated soils and petroleum hydrocarbon

based drill cuttings, including allowing application of such substances to lands previously permitted and used for such practices, modifying requirements for land application vehicles, revising time periods for land application, use of fertilizer, and changing post-application report requirements.

The Commission also amends OAC 165:10-7-31 regarding seismic operations to conform to amendments to the Seismic Exploration Regulation Act in Senate Bill Nos. 243 and 1665 (2012)(52 O.S. §§ 318.21 through 318.23); OAC 165:10-9-1 concerning commercial pits to allow deleterious substances associated with pipeline construction to be deposited in such pits; OAC 165:10-9-3 pertaining to site security at commercial disposal well surface facilities; OAC 165:10-11-4 to add expiration dates for Form 1001 Notifications of Intentions to Plug; OAC 165:10-17-7 concerning well tests to streamline initial tests for newly completed gas wells and recompleted gas wells involving new formations, annual testing or retesting of existing gas wells, durability of minimum allowables and deletion of the Form 1007A annual unallocated natural gas well survey for allowable purposes, and OAC 165:10-17-11 pertaining to maximum permitted rates of production for unallocated gas wells to change proration hearings from a semiannual to an annual basis.

The full text of these rules may be obtained by interested parties at the Oklahoma Corporation Commission's Oklahoma City Court Clerk's Office located in the Jim Thorpe Office Building, 2101 North Lincoln Boulevard, Oklahoma City, Oklahoma, 73105, at the Commission's Tulsa Court Clerk's Office located in the Kerr Building at 440 South Houston, Suite 114, Tulsa, Oklahoma, 74127, and on the Commission's website at http://www.occeweb.com.

*[OAR Docket #13-911; filed 5-24-13]*

## TITLE 165. CORPORATION COMMISSION CHAPTER 30. MOTOR CARRIERS

*[OAR Docket #13-754]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Intrastate Motor Carriers
Part 3. License Requirements
165:30-3-11. Insurance [AMENDED]
Subchapter 26. Nonconsensual Wrecker And Towing Services [NEW]
Part 1. Nonconsensual Wrecker And Towing Services Rate Change Applications [NEW]
165:30-26-1. Purpose [NEW]
165:30-26-2. Definitions [NEW]
165:30-26-3. Application; application package; and staff response to filed application package [NEW]
165:30-26-4. Limitations on filing rate cause [NEW]
Part 3. Response To Nonconsensual Towing Rate Complaints [NEW]
165:30-26-10. Receipt of nonconsensual towing rate complaints [NEW]
165:30-26-11. Review of nonconsensual towing rate complaints [NEW]
165:30-26-12. Nonconsensual towing rate complaint resolution [NEW]
165:30-26-13. Closure [NEW]
**AUTHORITY:**
Corporation Commission; Article IX, § 18 Okla. Const. and the Motor Carrier Act of 1995, specifically 47 O.S. § 230.24.
**COMMENT PERIOD:**
December 27, 2012 to February 15, 2013
**PUBLIC HEARING:**
March 6, 2013
**ADOPTION:**
March 6, 2013
**SUBMITTED TO THE GOVERNOR:**
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**SUBMITTED TO THE HOUSE:**
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**SUBMITTED TO THE SENATE:**
March 12, 2013
**GUBERNATORIAL APPROVAL:**
April 18, 2013
**LEGISLATIVE APPROVAL:**
Failure of the Legislature to disapprove the rules resulted in approval on May 9, 2013.
**FINAL ADOPTION:**
May 9, 2013
**EFFECTIVE DATE:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
None
**INCORPORATIONS BY REFERENCE:**
None
**ANALYSIS:**
The amendment in Subchapter 3 is proposed to address concerns presented to the Commission by the passenger carrier industry. The proposals in Subchapter 26 are needed to assist the Commission in effectively and efficiently regulating nonconsensual towing and storage rates, as the Commission currently has no such rules.
**CONTACT PERSON:**
Kathy Nelson, Assistant General Counsel, Office of General Counsel, Oklahoma Corporation Commission, 2101 N. Lincoln Blvd., P.O. Box 52000, Oklahoma City, OK 73152-2000, (405)522-1638.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 3. INTRASTATE MOTOR CARRIERS

### PART 3. LICENSE REQUIREMENTS

**165:30-3-11. Insurance**

(a) No motor carrier whose principal place of business is in Oklahoma shall conduct any operations in this State unless such operations are covered by a valid primary bond or insurance policy issued by an insurer authorized or approved by the Oklahoma Insurance Department. No motor carrier whose principal place of business is not in Oklahoma shall conduct any operations in this State unless such operations are covered by a valid bond or insurance policy issued by an insurer licensed or approved by the insurance regulatory authority of the state of their principal place of business or the Oklahoma Insurance Department. No holder of an authority shall conduct any operations before a proper certificate of insurance(s) has been filed with, and approved by the Commission. A surety bond containing all obligations provided by this Section may be substituted for an insurance policy.

(b) Every motor carrier shall file with, and must be approved by, the Commission a certificate on Form E or G certifying that there is in effect a valid bond or insurance policy covering operations in Oklahoma to protect the public against loss of life, injury, property damage, and including environmental restoration in minimum amounts, of combined single limits, for bodily injuries to, or death of all persons injured or killed in any accident, and loss or damage in any one accident to property or others (excluding cargo). Minimum liability insurance limits as set forth in 49 CFR Part 387 shall also be applicable to

intrastate operations unless otherwise specified in subsections (b)(1)-(4).

(1) Motor carriers of property using vehicles with a gross vehicle weight rating (GVWR) of 10,000 pounds or more:

(A) Transporting property, non-hazardous commodities or transporting hazardous waste, materials or substances not listed in 49 CFR Part 387.9 - $750,000.

(B) Transporting deleterious substances - $750,000.

(C) Transporting hazardous waste, materials, or substances- as required by 49 CFR, Part 387.9.

(2) Motor carriers of property using only vehicles with a GVWR under 10,000 pounds:

(A) Transporting commodities not listed in (B) of this paragraph- $300,000.

(B) Transporting hazardous waste, materials or substances - as required by 49 CFR Part 387.9.

(3) Motor carriers of the following types of property, materials, and products (also known or identified as restricted property) - $350,000:

(A) Sand, rock, gravel, rip-rap, aggregate or dirt.

(B) Asphaltic mixtures and similar mixtures and compositions (excluding concrete and concrete mixtures) used in road, highway and other ground surface paving.

(C) Unprocessed forestry products and by products thereof not in a finished state.

(D) Unprocessed agricultural commodities.

(E) Ordinary livestock.

(4) Motor carriers of passengers (manufacturer's designed seating capacity includes the driver):

(A) ~~Taxicab service utilizing~~Utilizing vehicles having a seating capacity of six (6) or less passengers ~~not operated on a regular route or between specified points~~ - $100,000.

(B) Utilizing vehicles having a seating capacity of seven (7) - nine (9) passengers - $750,000.

(~~B~~C) Utilizing vehicles having a seating capacity of ten (10) to fifteen (15) passengers ~~or less, other than as described in (A) of this paragraph~~ - $1,000,000.

(~~C~~D) Utilizing vehicles having a seating capacity of sixteen(16) or more passengers - $5,000,000.

(5) Motor carriers of household goods - $750,000.

(c) Every motor carrier of freight, except a motor carrier of household goods, shall be exempted from filing proof of cargo liability insurance. Every motor carrier of household goods shall file with, and be approved by, the Commission an additional certificate on Form H or J that there is in effect a valid bond or insurance policy issued by a State Insurance Department authorized provider as security required to compensate shippers or consignees for loss of or damage to property coming into the motor carrier's possession. Security in the amount of at least Five Thousand ($5,000) Dollars is required to cover loss of or damage to property carried on any one motor vehicle in connection with its transportation service and in the amount of $10,000 for the loss of or damage to or aggregate of losses of or damages to property occurring at any one time and place.

(d) Motor carriers of hazardous materials or hazardous waste shall maintain a properly executed Form MCS-82 or MCS-90 in effect as required by 49 CFR 387.

(e) The Commission may by order grant authority to operate or to continue operating as a motor carrier conditional upon carrying insurance coverage in amounts larger than prescribed by (b) of this Section.

(f) No certificate of insurance or surety bond filed with the Commission pursuant to this Section shall be cancelled, unless the authorization to conduct operations has been canceled, except after thirty (30) days written notice made to the Commission, on Form K or L, which notice shall be effective only upon actual receipt thereof by the Commission.

(g) Insurance certificates or surety bonds may be cancelled without the thirty (30) days written notice on Form K or L only when the authorization to operate has previously expired or cancelled, the motor carrier provides an affidavit stating no operations have been conducted and the effective date of the cancellation notice is not before the date the cancellation notice is received in the Commission.

(h) Insurance certificates or surety bonds not properly cancelled or expired shall be considered expired one year after the motor carrier's authorization to operate has been cancelled or expired.

(i) Insurance certificates or surety bonds approved by this Commission shall be replaced by more recent insurance certificates or surety bonds. The liability of the retiring insurer or surety shall be terminated as of the effective date of the replacement insurance certificate or surety bond provided the replacement is approved by this Commission.

(j) No certificate of insurance shall be filed with the Commission which contains a provision to the effect that liability thereunder may be limited or avoided because of the culpability, the recklessness, or the condition of the driver of the vehicle involved or any other restriction relating to the driving or operation of the vehicle.

(k) Every certificate of insurance filed with the Commission shall provide that the public is protected from damage sustained through operations of any and all vehicles operated by the motor carrier insured, whether or not listed or identified in the policy; and that liability is not limited by the description of any particular vehicle or route which may be traveled by the motor vehicle in transporting passengers or property under the certificate or permit or license.

(l) Every certificate of insurance filed with the Commission shall be executed by an officer or authorized agent of the insurance company; and if executed by an agent, a copy of his written authority or power of attorney to execute the same shall be attached to the certificate.

(m) When insurance is provided by more than one insurer in order to aggregate security limits for motor carriers, a separate insurance certificate and endorsement is required of each insurer.

(n) Every motor carrier shall maintain in force at all times all insurance required by state laws and by this Section. Failure for any cause to maintain any required insurance in force shall automatically and without notice suspend the license or authority of a motor carrier until proper insurance is filed.

(o) Whenever the license or authority of a motor carrier is suspended for failure to maintain in force insurance required by this Section, the carrier must file, within sixty (60) days after commencement of the suspension, proper certificate(s) of insurance as provided in this Section and a sufficient showing, by affidavit or otherwise, that no operations were conducted during the period that insurance was not in force (TDF 18).

(p) Whenever a motor carrier fails to provide proper certificates of insurance within sixty (60) days after suspension thereof as provided in this Section, the motor carrier's certificate or permit, license, or other authority shall be cancelled by operation of law, and without notice. A certificate or permit, license, or other authority so cancelled shall not be reinstated or otherwise made operative except upon proper showing, at a hearing, that the motor carrier was actually covered by proper insurance during the suspension or cancellation period, and that failure to file with the Commission was not due to the motor carrier's own negligence.

(q) Any motor carrier conducting operations under a suspended or cancelled authority, shall not be eligible to apply for a new authority for a period of not less than one hundred eighty (180) days. The one hundred eighty (180) day period shall be determined by either the date insurance on file expires or the date a violation is discovered, whichever occurrence is later.

(r) A person may not require indemnification from a motor carrier as a condition to the following:

(1) The transportation of property by the motor carrier.

(2) Entrance onto property by the motor carrier for the purpose of loading, unloading or transporting property.

(3) Subsection (r)(2) of this Section does not apply to a claim arising from damages or losses from the wrongful or negligent act or omission of the motor carrier.

(s) Insurance filings and cancellation notices required by this Chapter may be accepted electronically as set forth by the Transportation Division. Electronic insurance filings and cancellations shall be held to the same standard and carry the same force and effect as if accepted through traditional paper filings.

## SUBCHAPTER 26. NONCONSENSUAL WRECKER AND TOWING SERVICES

## PART 1. NONCONSENSUAL WRECKER AND TOWING SERVICES RATE CHANGE APPLICATIONS

### 165:30-26-1. Purpose

The purpose of this Subchapter is to define the specific financial, statistical, and other information required to be filed and made available with an application proposing an increase or change in rates, charges, or fees charged for the provision of nonconsensual wrecker or towing services. This Subchapter is intended to define the information required to be filed and made available in connection with a proposed rate increase or rate change in order to facilitate an investigation of and hearing on such proposed rate increase or rate change. This Subchapter does not preclude the filing or provision of any additional data, information, or calculations not herein specified, nor does this Subchapter preclude the Oklahoma Corporation Commission ("Commission") from requiring additional information as it deems necessary.

### 165:30-26-2. Definitions

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

**"Accounting method"** means generally accepted accounting practices recognized by the American Institute of Certified Public Accountants or other accounting methods approved by the Commission.

**"Application package"** means the application, the narrative explanation of the justification for the rate increase or rate change, all exhibits, schedules, testimony and evidence necessary to support the application.

**"Day"** means calendar day unless specifically defined otherwise.

**"Deficient filing"** means a filing which does not substantially comply with the formal or procedural requirements of this Subchapter and the Commission Rules of Practice.

**"Director"** means the Director of the Transportation Division of the Oklahoma Corporation Commission.

**"Nonconsensual towing rate complaint"** means any communication, whether verbal or written, from any person, which alleges that any wrecker service has billed rates, charges, or fees not authorized or in excess of those authorized by Commission Order. The Commission is not obligated to act on any complaint in which insufficient information is presented to establish that a violation has occurred.

### 165:30-26-3. Application; application package; and staff response to filed application package

(a) Applicant shall file with the Commission Court Clerk its request for a rate increase or rate change in a complete application package. Applicant shall also submit the filing fee with the application package, which is set forth in the Commission Rules of Practice. Applicant shall submit six (6) copies of the application package to the Commission Court Clerk at the time of filing.

(b) The application shall be in the form required by the Commission Rules of Practice for commencement of a cause.

(c) The application package shall contain the following:

(1) A narrative explanation of the justification for the rate increase or rate change;

(2) The application shall contain all exhibits, schedules, testimony, and evidence necessary to support the application and shall be assembled in sections with index tabs identifying each section for referencing convenience;

(3) Filed testimony shall reference the exhibits, schedules, and evidence in the same manner used to file the application package;

(4) All exhibits, schedules, testimony, and evidence shall be both factually and mathematically correct using generally accepted accounting methods.

(d) Service of the application shall be as required by the Commission Rules of Practice.

(e) The applicant shall maintain the application package. The application shall include information to inform all Respondents and other interested parties of the location where the application package is being maintained. Such information shall include the name, address, telephone number, fax number, and e-mail address of the person maintaining the application package. The applicant shall make the application package available to all Respondents and other interested parties for examination between the hours of 8:00 a.m. and 5:00 p.m. on Monday through Friday, excluding legal holidays as defined in the Commission Rules of Practice. The application package shall also be available for public inspection at the Office of the Commission Court Clerk.

(f) Unless otherwise indicated, all applicable provisions in the Commission Rules of Practice shall be followed in all nonconsensual wrecker and towing service causes.

(g) Within twenty-one (21) calendar days of the receipt of an application package, the Director shall file with the Commission and provide to the applicant a copy of the staff response regarding the compliance or deficiency of the application and/or application package.

(h) If the Director finds the application and/or application package is not in substantial compliance with the requirements of this Subchapter, the staff response shall state that the filing is a deficient filing. The deficiencies and the requirements necessary to cure the deficiencies shall be stated in the staff response. If the deficiencies noted in the staff response are not corrected within forty-five (45) calendar days of the date of the staff response, the application package shall be rejected. Resubmission of a rejected package shall be considered a new application package, and the application filing fee set forth in the Commission Rules of Practice shall be submitted with this filing.

**165:30-26-4. Limitations on filing rate cause**

At the time of filing a request for a rate increase or rate change or at the time of entering an appearance in a rate increase or rate change cause, the filer shall not have any outstanding obligation to the Commission or to a consumer as the result of a nonconsensual towing rate complaint.

## PART 3. RESPONSE TO NONCONSENSUAL TOWING RATE COMPLAINTS

**165:30-26-10. Receipt of nonconsensual towing rate complaints**

(a) Any nonconsensual towing rate complaint received by the Commission or any of its Divisions shall be recorded immediately upon receipt in such format as the Commission may designate.

(b) A written acknowledgement of receipt of a nonconsensual towing rate complaint will be communicated to the complainant, alleged violator, and other relevant parties, if known, within seven (7) calendar days following receipt of the nonconsensual towing rate complaint and shall provide the status of the nonconsensual towing rate complaint at that time. The written acknowledgement shall contain information necessary to identify the tow. The wrecker service invoice number, vehicle identification number, date, and time of the tow are examples of the kind of information that may be provided. The written acknowledgement shall also request initial records needed to commence the complaint investigation. Nothing herein restricts the Commission from requiring and examining additional records necessary to fully investigate a complaint.

**165:30-26-11. Review of nonconsensual towing rate complaints**

(a) The appropriate Division of the Commission shall immediately review each nonconsensual towing rate complaint and promptly refer any complaint concerning matters not regulated by the Commission to the appropriate state or federal agency.

(b) Nonconsensual towing rate complaints that are not referred shall be reasonably and sufficiently investigated, which may include on site investigation, to determine whether or not an action or actions should be initiated by the Commission.

(c) Nonconsensual towing rate complaints must be filed within the wrecker service documentation retention requirements of the Oklahoma Department of Public Safety.

**165:30-26-12. Nonconsensual towing rate complaint resolution**

(a) Nonconsensual towing rate complaint resolution is not achieved until a written determination is made by the Commission.

(b) If the complaint investigation results in a determination that restitution and/or a penalty, or other action is necessary, the full amount must be remitted within twenty (20) calendar days of the written determination to avoid enforcement action against the wrecker or towing service. Restitution payments must be remitted to the person taking responsibility for the tow bill, whereas, penalties assessed must be remitted to the Commission along with a copy of the written determination.

**165:30-26-13. Closure**

Nonconsensual towing rate complaints referred to other agencies, nonconsensual towing rate complaints that involve issues not within the Commission's jurisdiction, and nonconsensual towing rate complaints that involve issues for which an adequate remedy has already been implemented shall be closed in writing and a copy of the referral or other closure document shall be sent to the complainant, alleged violator, and other relevant parties, if known, within seven (7) calendar days of closure.

*[OAR Docket #13-754; filed 5-10-13]*

## TITLE 210. STATE DEPARTMENT OF EDUCATION
## CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES

*[OAR Docket #13-771]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 13. Student Assessment
210:10-13-11. Testing students with disabilities [AMENDED]
**AUTHORITY:**
70 O.S. § 3-104; 70 O.S. § 1210.507.; State Department of Education
**DATES:**
**Comment period:**
January 15, 2013 through February 15, 2013
**Public hearing:**
February 15, 2013
**Adoption:**
February 28, 2013
**Submitted to Governor:**
March 7, 2013
**Submitted to House:**
March 7, 2013
**Submitted to Senate:**
March 7, 2013
**Gubernatorial approval:**
April 18, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 7, 2013.
**Final adoption:**
May 7, 2013
**Effective:**
June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
The rule is amended to require that training in providing access to students with the most significant disabilities shall be provided to those who score assessments administered by public schools under the Oklahoma Alternate Assessment Program ("OAAP"). The OAAP is the school testing program administered to public school students with the most significant disabilities in accordance with the provisions of the Oklahoma School Testing Program Act and in compliance with the federal provisions of the No Child Left Behind Act and the Individuals with Disabilities Act.
**CONTACT PERSON:**
Stephanie Moser Goins, (405) 521-4890

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

### SUBCHAPTER 13. STUDENT ASSESSMENT

**210:10-13-11. Testing students with disabilities**

(a) Acceptable accommodations of the general assessments of the OSTP for students with disabilities shall be:

(1) specified in the student's IEP under the Individuals with Disabilities Education Act (IDEA); or

(2) specified for student served under the Americans With Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

(b) The use of test accommodations which deviate from established standardized test procedures for the general assessments of the OSTP shall be reported to the State Department of Education's Student Assessment Section.

(c) Large print and Braille versions of the tests may be utilized with students whose visual disabilities necessitate such accommodations. The Student must be utilizing large print or Braille in daily classwork as indicated on the student's IEP on file at the school district. To order large print or Braille tests, the district test coordinator shall indicate the quantities required at each grade level tested on the annual questionnaire.

(d) Students with disabilities who cannot be assessed in a valid and reliable manner with the general state assessment even with accommodations, as specified in the student's IEP, shall be assessed with an appropriate alternate assessment provided by the State Department of Education. Eligibility for an alternate assessment shall be determined annually by the student's IEP team. Alternate assessments may include, but not be limited to, portfolio assessments or modified assessments. The scores from alternate assessments shall be included in accountability calculations for the school, district, and state according to the standard AYP calculation procedures, as specified in federal law.

(e) Students with the most significant cognitive disabilities shall participate in an Alternate Assessment Program (OAAP) and should not exceed a small percentage of the special education population. The OAAP shall be designed for students who are participating in an alternative curriculum based on the Curriculum Access Resource Guide (CARG).

(f) The OAAP shall consist of a portfolio assessment, which may include authentic performance tasks. A portfolio assessment is a collection of student-generated or student-focused products that exhibit the alternative approach to teaching the Priority Academic Student Skills (PASS). The portfolio shall be scored by teams~~Teams~~ of teachers supervised by an individual who has received training in providing access to students with severe or profound disabilities from the Office of Special Education of the State Department of Education.~~shall score the OAAP portfolio.~~ If authentic performance tasks are used, teachers completing the portfolio shall be provided with information regarding these tasks during a specified time prior to the completion of the portfolio.

(g) Students with cognitive disabilities that inhibit their ability to attain, even after receiving appropriate instructional interventions, grade-level achievement standards within the same time frame as other students may demonstrate academic proficiency through participation in a statewide system of modified assessments. These assessments, the Oklahoma Modified Alternate Assessment Program (OMAAP), shall be based in the content drawn from the Priority Academic Students Skills (PASS) and shall be designed to be rigorous, reliable and valid measures of the academic content required of all students.

*[OAR Docket #13-771; filed 5-15-13]*

## TITLE 210. STATE DEPARTMENT OF EDUCATION
## CHAPTER 30. SCHOOL FACILITIES AND TRANSPORTATION

*[OAR Docket #13-772]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Facilities
210:30-3-3. Mobile classrooms [REVOKED]
**AUTHORITY:**
70 O.S. § 3-104; State Department of Education
**DATES:**
**Comment period:**
January 15, 2013 through February 15, 2013
**Public hearing:**
February 15, 2013
**Adoption:**
February 28, 2013
**Submitted to Governor:**
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**Gubernatorial approval:**
April 18, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 7, 2013.
**Final adoption:**
May 7, 2013
**Effective:**
June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
The revocation of the rule is necessary because the Oklahoma State Legislature no longer provides for emergency classroom facilities for use when schools are destroyed or extensively damaged as a result of natural disasters, and because the State Department of Education no longer maintains mobile classroom units.
**CONTACT PERSON:**
Stephanie Moser Goins, (405) 521-4890

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

### SUBCHAPTER 3. FACILITIES

**210:30-3-3. Mobile classrooms [REVOKED]**

~~(a) The Oklahoma Legislature has provided for emergency classroom facilities for use when schools are destroyed or extensively damaged as a result of natural disasters. Mobile classrooms constructed similarly to mobile homes have been obtained to fulfill this function.~~

~~(b) The primary objective of the program is to minimize the time that school is disrupted by fire, tornado, flood or other disaster. The success of this program will require the coordinated efforts of the local school officials and the State Department of Education.~~

~~(c) When mobile classrooms are requested and made available to an affected district on a temporary basis, the local school will be expected to prepare the site, provide utility connections, provide insurance and supply support facilities such as anchoring and walkways. They will pay for all moving cost to the school site and will similarly return the mobile units at the agreed upon time.~~

~~(d) An agreement will be made between the State Department of Education and local school district regarding the number of units to be located on site, time, etc. A school district may keep a mobile unit for one semester, and the agreement may be extended monthly for a second semester; however, no agreement may be extended past two (2) semesters, except in unusual circumstances as submitted to and approved by the State Board of Education.~~

*[OAR Docket #13-772; filed 5-15-13]*

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## TITLE 210. STATE DEPARTMENT OF EDUCATION
## CHAPTER 30. SCHOOL FACILITIES AND TRANSPORTATION

*[OAR Docket #13-769]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Transportation
210:30-5-1. District administration, operation and management of transportation [AMENDED]
210:30-5-3. Transportation of students [NEW]
210:30-5-4. Transportation for school activities [NEW]
210:30-5-5. Transportation routes and boundaries [NEW]
210:30-5-6. School buses [NEW]
210:30-5-7. Transportation of students with disabilities [NEW]
**AUTHORITY:**
70 O.S. § 3-104; 70 O.S. § 9-101; 70 O.S. § 9-101.1; 70 O.S. 9-105; 70 O.S. § 9-118; 47 O.S. § 15-109; 42 U.S.C. § 12101 et seq.; State Department of Education
**DATES:**
**Comment period:**
January 15, 2013 through February 15, 2013
**Public hearing:**
February 15, 2013
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**Submitted to Governor:**
March 7, 2013
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**Final adoption:**
May 7, 2013

**Effective:**
June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
The proposed changes to 210:30-5-1(a) reorganize the rule, which deals with several different transportation topics, by removing subsections (b)-(g) of 210:30-5-1 and renumbering them as separate sections (210:30-5-3 through 210:30-5-7).

47 O.S. § 15-109 requires the State Board of Education to adopt and enforce regulations governing the design and operation of school buses used for the transportation of school children in accordance with the provisions of the Federal Motor Vehicle Safety Standards. The amendment to the rule clarifies the procedure whereby an individual may become qualified to perform annual school bus inspections through the State Department of Education.
**CONTACT PERSON:**
Stephanie Moser Goins, (405) 521-4890

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

## SUBCHAPTER 5. TRANSPORTATION

### 210:30-5-1. District administration, operation and management of transportation

~~(a)~~ ~~**Administration.**~~ The local superintendent and local board of education shall be held responsible for applying ~~these~~the regulations in this subchapter to all pupil transportation under their administration and supervision. In keeping with this responsibility, each local board of education shall examine and periodically review the school district's bus fleet liability insurance coverage and its tort liability insurance coverage to assure such coverages are coordinated to protect the interest of the students, general public, and school district. Any school district maintaining a school may provide transportation with the approval of the State Board of Education.

~~(b)~~ ~~**Students.**~~

~~(1) A student must live in a school district authorized by law to furnish transportation.~~

~~(2) A student must live one and one-half (1 1/2) miles or more by commonly traveled road from the school attended. Students living less than one and one-half (1 1/2) miles from school may be transported, but shall not be counted in determining state aid.~~

~~(3) A normal school day consists of not less than six (6) hours, exclusive of lunch period, with the exception of the first and kindergarten grades. Transportation may be provided for kindergarten age students to and from school during the normally scheduled morning and evening bus operation. Districts desiring to provide additional transportation for kindergarten students at midday may do so at local district expense but it is not required.~~

~~(4) The local school district is responsible for providing transportation for an eligible special education student when transportation has been identified as "related service" necessary to enable the student to receive the educational services outlined in his/her Individualized Education Program (IEP).~~

~~(5) Students living in a school district not offering the grade which they are entitled to pursue are entitled to transportation to a school authorized by law to provide transportation to and from school provided they have been legally transferred and reside in the transportation area.~~

~~(c)~~ ~~**Activities.**~~ ~~All Oklahoma school districts shall develop policies and procedures authorizing transportation for extracurricular activities and community involvement purposes as authorized by 70 O.S. § 5-130.~~

~~(d)~~ ~~**Routes and boundaries.**~~ ~~All school bus routes shall be evaluated annually for safety and efficiency by the local school district supervisor of transportation or designee.~~

~~(1) Boundaries.~~

~~(A) A change in transportation area made after July 1, will not become effective until the next July 1, unless all boards of education affected agree to the proposed change.~~

~~(B) An elementary area that has been assigned to a high school transportation area may be changed to another high school transportation area by mutual agreement, in writing, by the three (3) boards of education affected and the approval of the State Board of Education.~~

~~(C) A part or all of an elementary school district that is isolated from the remainder of the school district's transportation area because of topography or previous annexations to another high school district, may be changed from one high school district's transportation area to another high school district's transportation area if the State Board of Education determines the change should be made on the basis of good administration.~~

~~(D) When a dependent school district is surrounded by an independent school district, that district must be designated as the transportation area for the high school students.~~

~~(E) An independent school district's transportation route may extend into a dependent school district's territory to pick up students whose grade is not offered in the dependent district.~~

~~(F) Upon mutual agreement of two (2) school districts, a school district may cross a portion of another district provided the doors of the school bus are kept closed.~~

~~(2) Petition for changing boundary lines.~~

~~(A) Seventy percent (70%) of the legal voters residing in a district who have children eligible to attend a public school (grades K through 12) or who have children under the age of five (5) may petition the State Board of Education for an election to change any part or all of a district from one transportation area to another.~~

~~(B) The State Board of Education will approve a convenient date for an election, supply ballots, and send a representative to assist with the election.~~

~~(C) If fifty-one percent (51%) of all such legal voters in the district vote for the change, the election makes a good recommendation to the State Board of Education.~~

~~(3) Changing areas, high school districts discontinued. High school districts and/or elementary school districts that must be placed in one or more high school transportation area or areas because a high school has been discontinued may be placed in a transportation area or areas on the following basis:~~

~~(A) All or part of District "A" may be placed in the transportation area of high school District "B", whose transportation area is not adjacent to District "A", provided high school District "C", which has transportation area that separates District "A" from District "B" transportation area, appears to be in jeopardy of being discontinued itself, and provided the number of people in District "A", who want to be placed in the transportation area of District "B", justifies such an arrangement. People in District "A" requesting these arrangements to enable them to annex to District "B" will be given much more consideration than those desiring to transfer only.~~

~~(B) No portion of a school district that is adjacent to a high school district's transportation area, but is separated from the high school area by a natural barrier, will be placed in the high school district's transportation area unless or until there is a road connecting the two (2) areas that is maintained in a manner that will justify the operation of a school bus over the road across the barrier.~~

~~(e) **School bus.**~~

~~(1) Equipment.~~

~~(A) Transportation equipment used to transport ten (10) or more public school children at one time shall meet all the minimum standards required for Types A, B, C, and D buses.~~

~~(B) Vehicles having a seating capacity of fewer than (10) passengers, excluding the operator, are not required to meet the State minimum standards for school buses.~~

~~(2) School bus inspections.~~

~~(A) A driver shall perform a daily pre-trip safety inspection of the vehicle. The inspection shall include brakes, lights, tires, exhaust system, gauges, windshield wipers, steering and fuel. The driver shall make a daily written report describing the condition of the bus and listing any deficiencies. This report is to remain on file with the local Chief Administrative Officer or designee for a period of ninety (90) days.~~

~~(B) A school district shall have each school bus mechanically inspected annually by an inspector approved by the Oklahoma State Department of Education.~~

~~(C) At least twice during each school year, each pupil who is transported in a school vehicle shall be instructed in safe riding practices, and participate in emergency evacuation drills. This instruction should be conducted during the first two weeks of each semester.~~

~~(3) School bus inspector qualifications.~~

~~(A) Any person licensed to inspect school buses by the Department of Public Safety under the Motor Vehicle Laws of Oklahoma prior to July 1, 2001, may be qualified to perform annual school bus inspections.~~

~~(B) Any person not meeting the qualifications as prescribed in (A) may be qualified to perform the annual school bus inspection by submitting proof to the Oklahoma State Department of Education that they meet the following qualifications:~~

~~(i) Two years experience as an automotive technician and certification by the Association for Automotive Service Excellence (ASE), or~~

~~(ii) Any person qualified to perform inspections under the Federal Motor Carrier Safety Act, appendix G.~~

~~(iii) Any person successfully completing an Inspector's Training Course approved by the Oklahoma State Department of Education.~~

~~(4) Standards and school bus specifications.~~

~~(A) The NATIONAL MINIMUM STANDARDS FOR SCHOOL BUSES applies to school bus construction and equipment. The Oklahoma State Board of Education has accepted the various methods bus manufacturers use to meet the requirements of these standards and all requirements under the Federal Motor Vehicle Safety Standards. (P.L. 89-563) The responsibility for compliance with Federal and State bus specifications rests with dealers and manufacturers.~~

~~(B) State Standards in addition to Federal Requirements also apply as follows:~~

~~(i) No school district may purchase any used or previously owned school bus unless the seller certifies prior to the sale, that the bus meets all safety standards and specifications for the date of manufacture of the used bus. Any school district that purchases a used or previously owned bus without the certification regarding compliance with standards shall forfeit their state transportation aid. The seller of any used or previously owned school bus shall certify to the local board of education that any such transportation equipment meets all Oklahoma and National Standards required for the date of its manufacture.~~

~~(ii) Church buses used for the purpose of transporting children to and from schools accredited by the State Department of Education shall be painted national school bus yellow.~~

~~(C) School districts that convert or have converted school buses to Liquefied Petroleum Gas (LPG) shall~~

~~comply with safety standards prescribed by the National Fire Protection Association, Standard No. 58 (NFPA 58) and the Oklahoma Liquefied Petroleum Gas Administration. In order to insure safe installation and proper maintenance of equipment, all personnel must also meet the following existing requirements of the Oklahoma Liquefied Petroleum Gas Administration: "No person, firm, corporation, association, or other entity shall engage in the manufacturing, assembling, fabrication, installing, or selling of any system, container, or apparatus to be used in this State in or for the transportation, storing, dispensing, or utilization of LPG, nor shall any transporter, distributor, or retailer of LPG store, dispense and/or transport over the highways of this State any LPG for use in this State in any system, container, apparatus, or appliance without having first obtained a permit to do so as provided..."~~

~~(f)~~ **~~Special education.~~**

~~(1) Loading responsibility. The local school district is responsible for the special education child from the time the student is loaded at the "home curb" until returned and unloaded at the "home curb". The parent or their designee is responsible for "door to curb", "curb to door", and "street crossing" of the child to the designated loading and unloading point.~~

~~(2) Extended boundaries. Based upon mutual agreement between two participating school districts, a school district offering special education classes may extend its transportation program to include the transportation of students qualifying for special education in an adjacent school district which does not offer special education classes.~~

~~(g)~~ **~~School bus driver certification.~~**

~~(1) General criteria.~~

~~(A) No board of education shall have authority to enter into any written contract with a school bus driver who does not hold a valid certificate issued by the State Board of Education authorizing said bus driver to operate a school bus.~~

~~(B) The State Board of Education requires all public school bus drivers to complete a school bus drivers training course approved by the State Department of Education to obtain a standard certificate.~~

~~(C) All school bus drivers must have not less than 20/40 vision (Snellen) in each eye and not less than 20/40 vision (Snellen) with both eyes and a minimum field of vision of 70 degrees horizontal median vision in each eye.~~

~~(D) Any person with diabetes requiring insulin by injection shall not be eligible for a school bus certificate unless the individual possesses and maintains a diabetic/medical exemption from the Oklahoma Department of Public Safety (DPS) or the Federal Motor Carrier Safety Administration (FMCSA), and has met all physical examination requirements of sub-section (I) of this section. Upon hire, exempted individuals will be required to:~~

~~(i) Self monitor their current blood glucose level one (1) hour prior to driving and approximately every four (4) hours after that time while driving a school bus by using a portable glucose monitoring device with a computerized memory, and take corrective action if necessary;~~

~~(ii) Maintain blood glucose logs, three months from the current date (or the date that insulin use began, whichever is shorter). If the employing district has cause to require a medical evaluation as authorized by sub-section (G), logs maintained pursuant to this sub-section must be provided to the medical doctor (MD) or doctor of osteopathy (DO) treating the individual. Blood glucose logs must be created by an electronic blood glucose meter that stores every reading, records date and time of reading, and from which data can be downloaded and printed.~~

~~(iii) Carry a source of rapidly absorbable glucose at all times while operating a school bus; and~~

~~(iv) Be examined annually by an Oklahoma board certified medical doctor (MD) or doctor of osteopathy (DO) who attests in writing:~~

~~(I) The individual demonstrates and has demonstrated a willingness to monitor and manage his or her diabetes;~~

~~(II) The individual is not likely to suffer any diminution in his or her driving ability due to diabetes.~~

~~(E) Superintendents or their designees who hire individuals who hold a diabetes exemption certification must keep on file in a separate medical record:~~

~~(i) A current copy of the diabetes exemption certificate of the individual;~~

~~(ii) The contact information of the board certified medical doctor (MD) or doctor of osteopathy (DO) who is treating the individual;~~

~~(iii) Record of the annual medical certification issued by the board certified medical doctor (MD) or doctor of osteopathy (DO) pursuant to sub-section (D) of this section; and~~

~~(iv) Copies of any medical certifications obtained pursuant to sub-section (G) of this section.~~

~~(F) Superintendents or their designees shall not allow an individual holding a diabetes exemption certificate to drive if their blood glucose level is outside of a range of 100 mg/dl to 400 mg/dl one (1) hour prior to driving. If the individual's blood glucose level is below 100 mg/dl or above 400 mg/dl, then the operator cannot operate a school bus or transport school children as an employee of any school district until the blood glucose measure is within the target range.~~

~~(G) In the event an individual holding a diabetes exemption is involved in an incident directly caused by the individual's diabetic condition, the individual cannot operate a school bus or transport school children as an employee of any school district until the individual has been certified in writing as medically~~

~~able to safely resume work related duties by the Oklahoma board certified medical doctor (MD) or doctor of osteopathy (DO) by whom they are being treated.~~

~~(H) The use of tobacco by a school bus driver is not permitted during the operation of the bus while hauling pupils. The use of any intoxicating or non-intoxicating alcoholic beverage by the driver eight (8) hours prior to or during the operation of a school bus is strictly prohibited. The use of any controlled dangerous substance seventy-two (72) hours prior to or during the operation of a school bus is strictly prohibited. The possession of any controlled dangerous substance on a school bus is strictly prohibited.~~

~~(I) All school bus drivers shall have an annual health certificate signed by a physician licensed by this state filed in the office of the local Chief Administrative Officer or designee attesting that such physician has examined the applicant and that the applicant has no sign or symptoms of ill health, and is otherwise, from the observation of such physician, physically and mentally capable of safely operating a school bus. As an alternative to the annual physical examination requirements for school bus drivers, school districts may adopt a policy that utilizes a biannual physical examination, provided the examination is in compliance with the physical qualifications and examination requirements of the Federal Motor Carrier Safety Act, Subpart E 391.41 to 391.50.~~

~~(J) Substitute and activity school bus drivers shall meet all the requirements prescribed for regular bus drivers.~~

~~(K) At a minimum, the Chief Administrative Officer or designee shall conduct an annual driving record check of all school bus drivers, including substitute and activity drivers. The Oklahoma State Department of Education shall be immediately notified of any violation(s) that make a school bus driver ineligible to hold an Oklahoma School Bus Driver's Certificate.~~

~~(L) The State Board of Education shall revoke the license of any certificate holder who fails to comply with the provisions of this section.~~

~~(M) School districts who fail to comply with the provisions of this section shall be subject to penalty pursuant to OAC 210:30-5-2.~~

~~(2) Certificate requirements.~~

~~(A) The Chief Administrative Officer or designee shall certify to the State Department of Education that each applicant submitted for Standard Five-Year Certification:~~

~~(i) Is at least 18 years of age.~~

~~(ii) Has successfully completed a special school bus drivers' course approved by the State Department of Education.~~

~~(iii) Holds a valid Commercial Drivers license (CDL) appropriate for the type of vehicle driven with the proper endorsements required by the Department of Public Safety.~~

~~(iv) Has not been convicted, plead guilty, or nolo contendere to a felony during the last ten years.~~

~~(v) Has passed a driving record check, and no certificate shall be issued to any person who, within the preceding three years:~~

~~(I) Has had a license suspended or revoked, canceled or withdrawn pursuant to the Implied Consent Laws at 47 O.S. §751 et seq.~~

~~(II) Has a conviction for a violation of 47 O.S. §11-902 which includes driving, operating or being in actual physical control of a vehicle while under the influence of alcohol or any intoxicating drug.~~

~~(III) Has been convicted or plead guilty to a violation of 47 O.S. §761, operating a motor vehicle while impaired by consumption of alcohol.~~

~~(IV) Has been convicted of any municipal violation of driving under the influence of alcohol or drugs or operating a motor vehicle while impaired or being in actual physical control of a motor vehicle while impaired.~~

~~(V) Has had four or more traffic violations. (excluding parking violations)~~

~~(B) The Chief Administrative Officer or designee shall certify to the State Department of Education that the applicant for an Emergency One-Year School Bus Driver Certificate (Not Renewable).~~

~~(i) Is at least 18 years of age.~~

~~(ii) Holds a valid Commercial Drivers License with the proper endorsements required by the Department of Public Safety.~~

~~(C) Requirements for Renewal of the Standard Five-Year Certificate include:~~

~~(i) Every five years, each driver shall have successfully completed 4 hours per year of inservice training approved by the State Department of Education.~~

~~(ii) The local Chief Administrative Officer or designee shall certify to the State Department of Education that the applicant meets all requirements for standard certification, [47 O.S. § 15-109]~~

~~(iii) Each applicant has a health certificate on file signed by a licensed physician and meets all vision requirements.~~

~~(iv) Each applicant has not been convicted or plead guilty of a felony in the last ten years, and~~

~~(v) A driving record has been checked and meets State Board of Education requirements for certification.~~

**210:30-5-3. Transportation of students**

(a) A student must live in a school district authorized by law to furnish transportation.

(b) A student must live one and one-half (1 1/2) miles or more by commonly traveled road from the school attended.

Students living less than one and one-half (1 1/2) miles from school may be transported, but shall not be counted in determining state aid.

(c) A normal school day consists of not less than six (6) hours, exclusive of lunch period, with the exception of the first and kindergarten grades. Transportation may be provided for kindergarten age students to and from school during the normally scheduled morning and evening bus operation. Districts desiring to provide additional transportation for kindergarten students at midday may do so at local district expense but it is not required.

(d) The local school district is responsible for providing transportation for those students with disabilities identified under the Individuals with Disabilities Education Act (IDEA) for whom transportation has been identified as "related service" necessary to enable the students to receive the educational services outlined in their Individualized Education Programs (IEPs).

(e) Students living in a school district not offering the grade which they are entitled to pursue are entitled to transportation to a school authorized by law to provide transportation to and from school provided they have been legally transferred and reside in the high school transportation area of the school they choose to attend.

**210:30-5-4. Transportation for school activities**

All Oklahoma school districts shall develop policies and procedures authorizing transportation for extracurricular activities and community involvement purposes as authorized by 70 O.S. § 5-130.

**210:30-5-5. Transportation routes and boundaries**

(a) **Evaluation.** All school bus routes shall be evaluated annually for safety and efficiency by the local school district supervisor of transportation or designee.

(b) **Boundaries.**

(1) A change in transportation area made after July 1 of each year, will not become effective until the next July 1, unless all boards of education affected agree to the proposed change.

(2) An elementary area that has been assigned to a high school transportation area may be changed to another high school transportation area by mutual agreement, in writing, by the three (3) boards of education affected and the approval of the State Board of Education.

(3) A part or all of an elementary school district that is isolated from the remainder of the school district's transportation area because of topography or previous annexations to another high school district may be changed from one high school district's transportation area to another high school district's transportation area if the State Board of Education determines the change should be made on the basis of good administration.

(4) When an elementary school district is surrounded by an independent school district, that district must be designated as the transportation area for the high school students.

(5) An independent school district's transportation route may extend into an elementary school district's territory to pick up students whose grade is not offered in the elementary school district.

(6) Upon mutual agreement of two (2) school districts, a school district may cross a portion of another district provided the doors of the school bus are kept closed.

(c) **Petition for changing boundary lines.**

(1) Seventy percent (70%) of the legal voters residing in a district who have children eligible to attend a public school (grades K through 12) or who have children under the age of five (5) may petition the State Board of Education for an election to change any part or all of a district from one transportation area to another.

(2) The State Board of Education will approve a convenient date for an election, supply ballots, and send a representative to assist with the election.

(3) If fifty-one percent (51%) of all such legal voters in the district vote for the change, the election makes a good recommendation to the State Board of Education.

(d) **Changing areas, high school districts discontinued.** High school districts and/or elementary school districts that must be placed in one or more high school transportation area or areas because a high school has been discontinued may be placed in a transportation area or areas on the following basis:

(1) All or part of District "A" may be placed in the transportation area of high school District "B", the transportation area of which is not adjacent to District "A", provided high school District "C", which has a transportation area that separates District "A" from District "B" transportation area, appears to be in jeopardy of being discontinued itself, and provided the number of people in District "A", who want to be placed in the transportation area of District "B", justifies such an arrangement. People in District "A" requesting these arrangements to enable them to annex to District "B" will be given much more consideration than those desiring to transfer only.

(2) No portion of a school district that is adjacent to a high school district's transportation area, but is separated from the high school area by a natural barrier, will be placed in the high school district's transportation area unless or until there is a road connecting the two (2) areas that is maintained in a manner that will justify the operation of a school bus over the road across the barrier.

**210:30-5-6. School buses**

(a) **Equipment.**

(1) Transportation equipment used to transport ten (10) or more public school children at one time shall meet all the minimum standards required for Types A, B, C, and D buses.

(2) Vehicles having a seating capacity of fewer than ten (10) passengers, excluding the operator, are not required to meet the State minimum standards for school buses.

(b) **School bus inspections.**

(1) A driver shall perform a daily pre-trip safety inspection of the vehicle. The inspection shall include brakes, lights, tires, exhaust system, gauges, windshield wipers,

steering and fuel. The driver shall make a daily written report describing the condition of the bus and listing any deficiencies. This report is to remain on file with the chief administrative officer of the local school district or designee of the chief administrative officer for a period of ninety (90) days.

(2) A driver shall perform a daily post-trip inspection of the interior passenger area of the vehicle to ensure that no pupils remain on the vehicle after the end of the route.

(3) A school district shall have each school bus mechanically inspected annually by an inspector approved by the Oklahoma State Department of Education.

(4) At least twice during each school year, each pupil who is transported in a school vehicle shall be instructed in safe riding practices, and participate in emergency evacuation drills. This instruction should be conducted during the first two weeks of each semester.

(c) **School bus inspector qualifications.**

(1) Any person licensed to inspect school buses by the Department of Public Safety under the Motor Vehicle Laws of Oklahoma prior to July 1, 2001, may be qualified to perform annual school bus inspections until July 1, 2014.

(2) Any person not meeting the qualifications as prescribed in (1) of this subsection may be qualified to perform the annual school bus inspection by submitting proof to the Oklahoma State Department of Education that they meet one or more of the following qualifications:

(A) Two years' experience as an automotive technician and certification by the Association for Automotive Service Excellence (ASE) in medium-heavy truck brake, transit bus brake, school bus brake, medium-heavy truck preventive maintenance inspection, or transit bus preventive maintenance inspection; or

(B) Any person qualified to perform inspections under the Federal Motor Carrier Safety Act, appendix G. and accompanying regulations at 49 CFR 396.19 will be qualified to inspect any school bus except for the brakes. Persons qualified to inspect brakes under 49 CFR 396.25 shall be qualified to inspect the brakes on any school bus; or

(C) Successful completion of an Inspector's Training Course approved by the Oklahoma State Department of Education.

(d) **Standards and school bus specifications.**

(1) The NATIONAL MINIMUM STANDARDS FOR SCHOOL BUSES applies to school bus construction and equipment. The Oklahoma State Board of Education has accepted the various methods bus manufacturers use to meet the requirements of these standards and all requirements under the Federal Motor Vehicle Safety Standards. (P.L. 89-563) The responsibility for compliance with Federal and State bus specifications rests with dealers and manufacturers.

(2) State Standards in addition to Federal requirements also apply as follows:

(A) No school district may purchase any used or previously owned school bus unless the seller certifies prior to the sale that the bus meets all safety standards and specifications for the date of manufacture of the used bus. Any school district that purchases a used or previously owned bus without the certification regarding compliance with standards shall forfeit its state transportation aid. The seller of any used or previously owned school bus shall certify to the local board of education that any such transportation equipment meets all Oklahoma and National Standards required for the date of its manufacture.

(B) Church buses used for the purpose of transporting children to and from schools accredited by the State Department of Education shall be painted National School Bus Yellow.

(3) School districts that convert or have converted school buses to Liquefied Petroleum Gas (LPG) shall comply with safety standards prescribed by the National Fire Protection Association, Standard No. 58 (NFPA-58) and the Oklahoma Liquefied Petroleum Gas Administration. In order to ensure safe installation and proper maintenance of equipment, all personnel must also meet the following existing requirements of the Oklahoma Liquefied Petroleum Gas Administration: "No person, firm, corporation, association, or other entity shall engage in the manufacturing, assembling, fabrication, installing, or selling of any system, container, or apparatus to be used in this State in or for the transportation, storing, dispensing, or utilization of LPG, nor shall any transporter, distributor, or retailer of LPG store, dispense and/or transport over the highways of this State any LPG for use in this State in any system, container, apparatus, or appliance without having first obtained a permit to do so as provided..."

**210:30-5-7. Transportation of students with disabilities**

(a) **Loading responsibility.** The local school district is responsible for transporting children with disabilities whose IEPs require transportation by the school district as a "related service". This responsibility for transportation begins from the time the student is loaded at the "home curb" until returned and unloaded at the "home curb". The parent or their designee is responsible for "door-to-curb", "curb-to-door", and "street crossing" of the child to the designated loading and unloading point.

(b) **Extended boundaries.** Based upon mutual agreement between two participating school districts, a school district offering special education classes may extend its transportation program to include the transportation of students qualifying for special education in an adjacent school district which does not offer special education classes.

*[OAR Docket #13-769; filed 5-15-13]*

## TITLE 210. OKLAHOMA STATE DEPARTMENT OF EDUCATION CHAPTER 35. STANDARDS FOR ACCREDITATION OF ELEMENTARY, MIDDLE LEVEL, SECONDARY, AND CAREER AND TECHNOLOGY SCHOOLS

*[OAR Docket #13-770]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Standards for Elementary, Middle Level, Secondary, and Career and Technology Schools
Part 21. Standard XI: Accreditation Status
210:35-3-201. Statement of the standard [AMENDED]
**AUTHORITY:**
70 O.S. § 3-104; 70 O.S. § 3-104.4; 70 O.S. § 1210.541; State Department of Education
**DATES:**
**Comment period:**
January 15, 2013 through February 15, 2013
**Public hearing:**
February 15, 2013
**Adoption:**
February 28, 2013
**Submitted to Governor:**
March 7, 2013
**Submitted to House:**
March 7, 2013
**Submitted to Senate:**
March 7, 2013
**Gubernatorial approval:**
April 18, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 7, 2013.
**Final adoption:**
May 7, 2013
**Effective:**
June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
The rule sets forth the statement of the standard for accreditation status of school sites and designates the categories of classification of schools for purposes of accreditation by the State Department of Education. The amendments to the rule to reflect the current categories of schools designated as schools in need of improvement under the accountability system required to be developed by 70 O.S. § 1210.541 and federal law provisions of the No Child Left Behind Act.
**CONTACT PERSON:**
Stephanie Moser Goins, (405) 521-4890

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

### SUBCHAPTER 3. STANDARDS FOR ELEMENTARY, MIDDLE LEVEL, SECONDARY, AND CAREER AND TECHNOLOGY SCHOOLS

### PART 21. STANDARD XI: ACCREDITATION STATUS

**210:35-3-201. Statement of the standard**

(a) Each school site must submit an Application for Accreditation to the Accreditation Standards Section of the State Department of Education by the due date specified on the Application. School sites are accredited for one year. An accredited school site shall meet all regulations and statutory requirements at the beginning of and throughout the school year.

(b) Accreditation status of school sites shall be classified according to the following categories:

(1) Accredited With No Deficiencies--All standards are being met.

(2) Accredited With Deficiencies--A school site fails to meet one or more of the standards but the deficiency does not seriously detract from the quality of the school's educational program.

(3) Accredited With Warning--A school site:

(A) fails to meet one or more of the standards and the deficiency seriously detracts from the quality of the school's educational program; and/or

(B) is ~~declared as a School Improvement School (to be implemented in school year 2008-09)~~ designated as a school in need of improvement in school years 2011-2012 or later;

(4) Accredited With Probation--A school site:

(A) consistently fails to remove or make substantial progress towards removing all deficiencies noted the previous year; and/or,

(B) consistently violates regulations; and/or,

(C) deliberately and unnecessarily violates one or more of the regulations; and/or

(D) is declared as a School Improvement School ~~year three (3) or beyond (to be implemented in school year 2008-09).~~ in school years 2009-2010 and 2010-2011 and designated as a school in need of improvement in school year 2011-2012; and/or;

(E) is designated as a school in need of improvement for three or more consecutive years beginning in school year 2011-2012.

(5) Nonaccredited--The school site is no longer recognized by the State Board of Education.

(c) If a school site is placed on warning or probation, the school board and administration will meet with a committee from the Accreditation Section to review their accreditation status. After the review from the committee, a determination will be made concerning warning, probation or nonaccredited status. The Accreditation Section will then present a recommendation to the State Board of Education.

*[OAR Docket #13-770; filed 5-15-13]*

# TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 4. RULES OF PRACTICE AND PROCEDURE

*[OAR Docket #13-779]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
252:4-1-3. Organization [AMENDED]
252:4-1-5. Availability of a record [AMENDED]
Subchapter 7. Environmental Permit Process
Part 1. The Process
252:4-7-13. Notices [AMENDED]
252:4-7-15. Permit issuance or denial [AMENDED]
252:4-7-18. Pre-issuance permit review and correction [AMENDED]
252:4-7-20. Agency review of final permit decision [NEW]
Subchapter 9. Administrative Proceedings
Part 3. Individual Proceedings
252:4-9-32. Individual proceedings filed by others [AMENDED]
**AUTHORITY:**
Environmental Quality Board, 27A O.S. § 2-2-101 (Board as rulemaking body for DEQ); Environmental Quality Code, 27A O.S.§ 2-3-201 (DEQ Executive Director powers and duties); Oklahoma Administrative Procedures Act, 75 O.S.§ 307 (requiring rulemaking by each agency for filing and disposition of declaratory ruling petitions).
**DATES:**
**Comment period:**
January 15 through February 15, 2013
**Public hearing:**
February 22, 2013, Environmental Quality Board
**Adoption:**
February 22, 2013
**Submitted to Governor:**
February 27, 2013
**Submitted to House:**
February 27, 2013
**Submitted to Senate:**
February 27, 2013
**Gubernatorial Approval:**
April 8, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on April 25, 2013
**Final adoption:**
April 25, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**ANALYSIS:**
The proposed changes are needed: (1) to update DEQ's Rules of Practice and Procedure due to recent statutory changes made by the Legislature; (2) to correct errors in the text of the rules; (3) to clarify permit review and correction opportunities for an applicant prior to issuance of a permit by the DEQ; (4) to clarify the process for a permit applicant who wishes to seek agency review of a final permit decision and what constitutes the administrative record for such a review; and (5) to clarify that a declaratory ruling request is a prerequisite to seeking judicial review of a final permit decision. These proposed changes are of general applicability to DEQ programs and are not within the jurisidiction of a particular advisory council.
**CONTACT PERSON:**
Martha Penisten, DEQ General Counsel, (405) 702-7184, 707 North Robinson, Oklahoma City, Oklahoma 73102. Mailing address is P.O. Box 1677, Oklahoma City, OK 73101-1677. E-mail address is martha.penisten@deq.ok.gov.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

### 252:4-1-3. Organization

(a) **Environmental Quality Board.** The Environmental Quality Board consists of thirteen (13) members, appointed by the Governor with the advice and consent of the Senate, selected from the environmental profession, general industry, hazardous waste industry, solid waste industry, water usage, petroleum industries, agriculture industries, conservation districts, local city or town governments, rural water districts, and statewide nonprofit environmental organizations. (See further 27A O.S.§ 2-2-101.)

(b) **Advisory Councils.** There are seven advisory councils.~~, each consisting~~All councils, except one with ten (10) members, consist of nine (9) members appointed by the Speaker of the House of Representatives, the President Pro Tempore of the Senate or the Governor. (See further 27A O.S.§ 2-2-201 and 59 O.S.§ 1101 *et seq.*)

(c) **DEQ.** The DEQ consists of the following divisions: Administrative Services, Air Quality, Land Protection, Water Quality, Environmental Complaints and Local Services, ~~Customer Services and the~~and State Environmental Laboratory~~.~~Services.

### 252:4-1-5. Availability of a record

(a) **Availability.** Records of the Board, Advisory Councils, and DEQ, not otherwise confidential or privileged from disclosure by law, shall be available to the public for inspection and copying at the DEQ's principal office during normal business hours. Information, data or materials required to be submitted to the DEQ in a permit application process shall be made available to the public in accordance with the Oklahoma Uniform Environmental Permitting Act (27A O.S.§ 2-14-101 *et seq.*) and the rules in this Chapter. The DEQ may take reasonable precautions in order to ensure the safety and integrity of records under its care.

(b) **Removal.** A record may be removed from the DEQ's offices or storage areas only with prior authorization from and under the supervision of the Records Coordinator or his/her designee.

(c) **Reproduction.**

(1) **By DEQ.** The DEQ may limit the number of copies made and the time and personnel available for reproduction of records requested by a member of the public.

(2) **Commercial reproduction.** With advance notice to the DEQ, a person may arrange for the pick-up, reproduction and return of records by a commercial copying service at his/her own expense, only if the Records Coordinator or his/her designee determines that the DEQ's staff or equipment is inadequate to perform all or part of the project.

(3) **Other.** With prior DEQ approval, a person may bring in and use his/her own copy machine.

(d) **Confidentiality.** Any person asserting a claim of confidentiality for any document submitted to the Board, Council or DEQ must substantiate the claim upon submission. The DEQ will make a determination on the claim and notify the person asserting the claim within a reasonable time. Each program may have more specific requirements, as required by state law or federal rule. [See 27A O.S.§ 2-5-105~~(18)~~(17) and 40 CFR ~~§~~Part 2 Subpart B, particularly § 2.301 (Clean Air Act),§ 2.302 (Clean Water Act),§ 2.304 (Safe Drinking Water Act),§ 2.305 (Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act), and § 2.310 (Comprehensive Environmental Response, Compensation, and Liability Act, as amended by Superfund Amendments and Reauthorization Act)].

(e) **Certification.** Copies of official records of the Board, Advisory Councils or DEQ may be certified by the Executive Director or his/her designees.

(f) **Charge.** The DEQ's administrative fee schedule applies to in-house copying or reproduction of records for or by members of the public.

## SUBCHAPTER 7. ENVIRONMENTAL PERMIT PROCESS

## PART 1. THE PROCESS

### 252:4-7-13. Notices

(a) **Statutory requirements for notice.** The Uniform Environmental Permitting Act requires an applicant to give notice in accordance with 27A O.S.§ 2-14-301.

(b) **Notice to landowner.** Applicants shall certify by affidavit that they own the real property, have a current lease or easement which is given to accomplish the permitted purpose or have provided legal notice to the landowner.

(c) **Notice content.** The applicant shall provide DEQ with a draft notice for approval prior to publication. All published legal notice(s) shall contain the:

(1) Name and address of the applicant;

(2) Name, address and legal description of the site, facility and/or activity;

(3) Purpose of notice;

(4) Type of permit or permit action being sought;

(5) Description of activities to be regulated;

(6) Locations where the application may be reviewed;

(7) Names, addresses and telephone numbers of contact persons for the DEQ and for the applicant;

(8) Description of public participation opportunities and time period for comment and requests; and

(9) Any other information required by DEQ rules.

(d) **Proof of publication.** Within twenty (20) days after the date of publication, an applicant shall provide the DEQ with a written affidavit of publication for each notice published. In case of a mistake in a published notice, the DEQ shall require a legal notice of correction or republication of the entire notice, whichever is appropriate. Inconsequential errors in spelling, grammar or punctuation shall not be cause for correction or republication.

(e) **Exception to notice requirement.** Applicants for solid waste transfer station permits may be exempt from public meeting requirements under 27A O.S.§ 2-10-307.

(f) **Additional notice.**

(1) Applicants for a NPDES, RCRA or UIC permit are subject to additional notice provisions of federal requirements adopted by reference as DEQ rules.

(2) Applicants for a proposed wastewater discharge permit that may affect the water quality of a neighboring state must give written notice to the environmental regulatory agency of that state. ~~[27A O.S.§ 2-5-112(E)]~~[27A O.S.§ 2-6-203(A)(7)]

(3) Applicants for a landfill permit shall provide notice by certified mail, return receipt requested, to owners of mineral interests and to adjacent landowners whose property may be substantially affected by installation of a landfill site. See *DuLaney v. OSDH*, 868 P.2d 676 (Okl. 1993).

(g) **Additional notice content requirements for Clean Air Act Permits.** In addition to the notice provisions of 27A O.S.§§ 2-14-301 and 2-14-302 and other provisions of this section, the following requirements apply.

(1) Applicants shall give notice by publication in a newspaper of general circulation in the area where the source is located; to persons on a mailing list developed by the DEQ, including those who request in writing to be on the list; and by other means if determined by the Executive Director to be necessary to assure adequate notice to the affected public.

(2) All published notice(s) for permit modification shall identify the emissions change involved in the modification.

(3) An applicant for a Part 70 permit that may affect the air quality of a neighboring state must give written notice to the environmental regulatory agency of that state. [27A O.S.§ 2-5-112(E)]

(4) An operating permit may be issued to an applicant for a new Part 70 operating permit without public review if the operating permit is based on a construction permit that meets the requirements of 252:4-7-32(b)(1)(B) and the public notice for the construction permit contains the following language.

(A) This permit is subject to EPA review, EPA objection, and petition to EPA, as provided by 252:100-8-8 and 40 CFR § 70.8.

(B) If the operating permit has conditions which do not differ from the construction permit's operating conditions in any way considered significant under 252:100-8-7.2(b)(2), the operating permit will be issued without public notice and comment; and,

(C) The public will not receive another opportunity to provide comments when the operating permit is issued.

**252:4-7-15. Permit issuance or denial**

(a) **Compliance required.** A new, modified or renewed permit or other authorization sought by the applicant shall not be issued until the DEQ has determined the application is in substantial compliance with applicable requirements of the Code and DEQ rules.

(b) **Conditions for issuance.** The Department may not issue a new, modified or renewed permit or other authorization sought by the applicant if:

(1) The applicant has not paid all monies owed to the DEQ or is not in substantial compliance with the Code, DEQ rules and the terms of any existing DEQ permits and orders. The DEQ may impose special conditions on the applicant to assure compliance and/or a separate schedule which the DEQ considers necessary to achieve required compliance; or

(2) Material facts were misrepresented or omitted from the application and the applicant knew or should have known of such misrepresentation or omission.

~~(c) **Burden of persuasion.** The applicant bears the burden of persuading the agency that the permit should issue. Title 75 O.S.§ 307 is the appropriate mechanism to address any alleged failure by the DEQ to conform the issuance or denial of the permit to the requirements of a Final Order.~~

**252:4-7-18. Pre-issuance permit review and correction**

(a) **Applicant review.** The DEQ ~~may ask~~may offer an applicant the opportunity to review its permit for calculation and clerical errors or mistakes of fact or law before ~~the~~a draft permit is issued.

(b) **Correction.** The DEQ may correct any permit before it is issued. Additionally, the DEQ may meet with any applicant to assess the applicant's request for significant corrections or changes in fact or law before a permit is issued.

(~~1~~c) **Notice of significant corrections.** For permits based on Tier II and III applications, an applicant shall publish or re-publish legal notice in one newspaper local to the site of any correction or change proposed by the DEQ which significantly alters a facility's permitted size, capacity or limits.

(~~2~~1) **Comments.** The DEQ may open a public comment period and/or reconvene a public meeting and/or administrative hearing to receive public comments on the proposed correction(s).

(~~3~~2) **Burden of Persuasion.** The applicant bears the burden of persuading the agency that any changes or corrections requested comply with the law and that the permit should issue.

**252:4-7-20. Agency review of final permit decision**

(a) **Agency review.** Unless a specific permit review process is otherwise provided in rules promulgated by the Board, an applicant who filed comments on the draft permit or participated in the public hearing, if any, may use the declaratory ruling procedure described in this Chapter to initiate agency review of a final permit decision.

(b) **Failure to file comments.** Any person who failed to file comments or participate in the public hearing on the draft permit may petition for declaratory ruling only to the extent of changes from the draft to the final permit decision.

(c) **Administrative record.** The administrative record for agency review of a final permit deision shall consist of:

(1) the permit application on file with the DEQ, as amended;

(2) all written comments received during the public comment period;

(3) the tape or transcript of the public meeting, if any;

(4) documents resulting from the DEQ's review of the permit application and public comments;

(5) the draft permit, fact sheet and response to comments, if any, issued by the DEQ;

(6) all published notices;

(7) the tape or transcript of the administrative hearing(s) held on a proposed Tier III permit, if any;

(8) the written materials submitted at an administrative hearing held on a proposed Tier III permit, if any;

(9) the final environmental impact statement and supplements, if any; and

(10) the final permit or denial.

## SUBCHAPTER 9. ADMINISTRATIVE PROCEEDINGS

## PART 3. INDIVIDUAL PROCEEDINGS

**252:4-9-32. Individual proceedings filed by others**

(a) **Request for administrative hearing in response to Order.** A request for an individual proceeding initiated by the Respondent named in an Order shall be in writing and shall specifically set forth the Respondent's objections to the Order.

(b) **Administrative hearing on Tier III permits.** An individual proceeding on a proposed permit for a Tier III application may be requested in accordance with 27A O.S.§ 2-14-304(C)(1).

(c) **Style.** The style of the case shall be in accordance with the format in Appendix D.

(d) **Content.** All requests for individual proceedings must be in writing, contain a brief statement of the basis of the request and the name and address of each requester, and be signed by the requester or an authorized representative.

(e) **Declaratory ruling.** Any person who alleges that any DEQ rule, ~~or~~ order or final permit decision interferes with or impairs, or threatens to interfere with or impair, his/her legal rights may petition the DEQ, formally requesting a declaratory ruling on the applicability of the rule, ~~or~~ order or final permit decision. After the petition is filed, the DEQ shall provide a copy to the Board.

(1) **Time.** Any person who requests a declaratory ruling on the applicability of an order must file the petition within twenty (20) working days of receipt of the order.

(2) **Form and content of petition.** All petitions shall be in writing and filed with the Administrative Law Clerk.

The petition shall include the information and follow the format in Appendix B.

(3) **Determination.** Petitions for declaratory rulings shall be decided by the DEQ. ~~Rulings~~Written rulings shall state the findings of fact and conclusions of law upon which they are based. If the DEQ refuses to make a ruling or begin an individual proceeding within 30 days of receipt, the petition shall be deemed to have been denied. If the DEQ begins an individual proceeding on the petition, it shall offer an opportunity for a hearing to the petitioner. After the DEQ issues a ruling or the Executive Director issues a final order, the DEQ shall provide a copy of the ruling or final order to the Board at its next available meeting.

(4) **Mailing.** The DEQ shall mail a copy of the ruling or final order to the petitioner.

(5) **Prerequisite to judicial review.** A ruling, or a refusal to rule, in response to a petition filed with the DEQ for a declaratory ruling is a prerequisite to seeking judicial review of a final permit decision pursuant to 75 O.S.§ 307.

*[OAR Docket #13-779; filed 5-16-13]*

## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
## CHAPTER 4. RULES OF PRACTICE AND PROCEDURE

*[OAR Docket #13-779A]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 7. Environmental Permit Process
Part 7. Water Quality Division Tiers and Time Lines
252:4-7-73 [AMENDED]
252:4-7-74 [AMENDED]
**AUTHORITY:**
Environmental Quality Board, 27A O.S.§ 2-2-101; Water Quality Management Advisory Council, 27A O.S.§ 2-2-201; and 27A O.S.§§ 1-3-101, 2-3-202, 2-3-402, 2-3-501, 2-6-103, 2-6-203, 2-6-402 and 2-6-501.
**DATES:**
**Comment period:**
December 1, 2012, through December 31, 2012
**Public hearing:**
January 8, 2013 and February 22, 2013
**Adoption:**
February 22, 2013
**Submitted to Governor:**
February 27, 2013
**Submitted to House:**
February 27, 2013
**Submitted to Senate:**
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**Gubernatorial approval:**
April 8, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on April 25, 2013
**Final adoption:**
April 25, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATION BY REFERENCE:**
n/a
**ANALYSIS:**
The changes being proposed are to correct unintended consequences from the amendments made during last year's rulemaking effort to include reclaimed water permits in the Tier classifications. By replacing "wastewater" with "reclaimed water" the Department inadvertently caused the land application of "biosolids" and "industrial wastewater" to be omitted from the Tier classifications.
**CONTACT PERSON:**
The contact person is Mark Hildebrand. Mark may be contacted at: Mark.Hildebrand@deq.ok.gov (e-mail), (405) 702-8100 (phone) or (405) 702-8101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The DEQ's mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 7. ENVIRONMENTAL PERMIT PROCESS

## PART 7. WATER QUALITY DIVISION TIERS AND TIMELINES

### 252:4-7-73. Water quality applications - Tier I

The following water quality authorizations require Tier I applications.

(1) Permit for flow-through impoundment(s) as part of the pretreatment process.

(2) Permit renewal for a facility with an expiring permit for industrial non-discharging impoundment or industrial septic tank system.

(3) Permit renewal for an expiring permit with minor or no change(s) for land application of sludge, biosolids, industrial wastewater and/or reclaimed water for same site.

(4) New, modified or renewed authorization under a general permit.

(5) Approval of new pretreatment program.

(6) Closure plan approval.

(7) Certifications issued pursuant to Section 401 of the Clean Water Act.

(8) Approval of exemption for water line extensions.

(9) Approval of exemption for water distribution, water reuse distribution and wastewater collection systems.

(10) Approval for alternative individual on-site sewage treatment systems.

(11) Approval for alternative small public on-site sewage treatment systems.

(12) Residential development approval.

(13) Transfer of discharge permit.

(14) Minor modification of discharge permit.

(15) Modification of an existing individual municipal permit for land application of biosolids and/or reclaimed water.

(16) Modification of or addition to an existing permitted municipal wastewater treatment system (including sewer line extensions).
(17) Modification of or addition to an existing permitted public water supply treatment and/or distribution system (including line extensions).
(18) Modification of or addition to an existing permitted water reuse treatment and/or distribution system (including line extensions).
(19) Modification of or addition to an existing permitted industrial non-discharging impoundment, industrial septic tank system, and/or industrial wastewater treatment system.
(20) Modification of an approved pretreatment program.
(21) Administrative amendment of permits or other authorizations for the correction of administrative or typographical errors.
(22) New, modified or renewed individual categorical or significant industrial user pretreatment permit.
(23) Modification of or addition of impoundment(s) to an existing permitted industrial wastewater treatment system.

**252:4-7-74. Water quality applications - Tier II**

The following water quality authorizations require Tier II applications.
(1) Permit to construct a new municipal wastewater treatment, and/or collection system, excluding line extensions.
(2) Permit to construct a new public water supply treatment and/or distribution system, excluding water line extensions.
(3) Permit to construct a new water reuse treatment and/or distribution system, excluding line extensions.
(4) New discharge permit for minor facility.
(5) Individual storm water permit.
(6) New permit for industrial non-discharging impoundment, industrial septic tank, or industrial wastewater system.
(7) New individual permit for land application of sludge, biosolids, industrial wastewater and/or reclaimed water.
(8) Permit renewal for a facility with expiring discharge permit.
(9) Permit renewal for a facility with expiring individual storm water discharge permit.
(10) Variance including thermal components of effluent limitations for an individual discharge permit.
(11) Major modification of discharge permit.
(12) Modification of an individual industrial permit for land application of sludge and/or wastewater.
(13) New, modified or renewed general permit.

*[OAR Docket #13-779A; filed 5-16-13]*

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# TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
# CHAPTER 100. AIR POLLUTION CONTROL

*[OAR Docket #13-780]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 2. Incorporation by Reference
252:100-2-3 [AMENDED]
Appendix Q. Incorporation by Reference [REVOKED]
Appendix Q. Incorporation by Reference [NEW]
**AUTHORITY:**
Environmental Quality Board, 27A O.S. Sections 2-2-101 and 2-2-201; and Oklahoma Clean Air Act, 27A O.S. Sections 2-5-101 *et seq.*
**DATES:**
**Comment period:**
June 15, 2012 through July 18, 2012
September 17, 2012 through November 14, 2012
**Public hearing:**
July 18, 2012
November 14, 2012
February 22, 2013
**Adoption:**
February 22, 2013
**Submitted to Governor:**
February 27, 2013
**Submitted to House:**
February 27, 2013
**Submitted to Senate:**
February 27, 2013
**Gubernatorial approval:**
April 8, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on April 25, 2013
**Final adoption:**
April 25, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
**Incorporated standards:**
Date of CFR provisions incorporated by reference in these rules is changed to " as they existed on September 13, 2012", 40 CFR Part 60, Subpart FFFF is no longer incorported by reference; and the following additional provisions are incorporated by reference; and the following additional provisions are incorporated by reference: Appendix P to Part 51 - Minimum Emission Monitoring Requirements
40 CFR Part 60, Subpart OOOO
40 CFR Part 63, Subpart DDDD
40 CFR Part 63, Subpart JJJJJ
40 CFR Part 63, Subpart KKKKK
40 CFR Part 63, Subpart UUUUU
40 CFR Part 63, Subpart HHHHHHH
**Incorporating rules.**
252:100-2-3
Appendix Q. Incorporation By Reference
**Availability:**
The standards are on file at the Department of Environmental Quality, 707 North Robinson, Oklahoma City, Oklahoma, 73102, and are available to the public for examination Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m., excluding state holidays.
**ANALYSIS:**
The Department is proposing changes to Subchapter 2, Incorporation By Reference, to update the effective date of Appendix Q and to clarify language. In addition, the Department is proposing to update the federal regulations incorporated by reference in Appendix Q. The existing Appendix Q will be revoked and a new Appendix Q will be adopted. These proposals are part of the annual review of Title 40, Code of Federal Regulations (40 CFR) incorporations by reference.

**CONTACT PERSON:**
Cheryl Bradley, Department of Environmental Quality, Air Quality Division, 707 North Robinson, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, (405) 702-4100

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 2. INCORPORATION BY REFERENCE

**252:100-2-3. Incorporation by reference**

Except as provided under this section, the provisions of 40 CFR listed in Appendix Q are hereby incorporated by reference as they existed on ~~August 1, 2011~~September 13, 2012.

(1) **Inclusion of 40 CFR citations and definitions.** When a provision of 40 CFR is incorporated by reference, all citations contained therein are also incorporated by reference.

(2) **Inconsistencies or duplications of requirements or incorporation dates.**

(A) ~~in~~In the event that there are inconsistencies or duplications between the requirements of this Chapter and the requirements of those provisions incorporated by reference in Appendix Q or elsewhere in this Chapter, the more stringent requirements shall apply.

(B) In the event that a specific date of incorporation is indicated in Appendix Q or a subchapter of this Chapter, the specified date of incorporation shall apply.

(3) **Terminology related to 40 CFR.** For purposes of interfacing with 40 CFR and unless the context clearly indicates otherwise, the following terms apply.

(A) "Administrator" is synonymous with "Executive Director."

(B) "U.S. Environmental Protection Agency" or "EPA" is synonymous with "Department of Environmental Quality" or~~(DEQ)~~"DEQ".

## APPENDIX Q. INCORPORATION BY REFERENCE [REVOKED]

## APPENDIX Q. INCORPORATION BY REFERENCE [NEW]

Except as provided under OAC 252:100-2-3, the following provisions of Title 40 of the Code of Federal Regulations are hereby incorporated by reference as they existed on September 13, 2012, unless otherwise noted.

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 50 | n/a | Appendix B to Part 50 - Reference Method for the Determination of Suspended Particulate Matter in the Atmosphere (High-Volume Method) |
| 50 | n/a | Appendix J to Part 50 - Reference Method for the Determination of Particulate Matter as $PM_{10}$ in the Atmosphere |
| 51 | F | Paragraph 51.100(s)(1) only of Subpart F, Procedural Requirements |
| 51 | n/a | Appendix P to Part 51 - Minimum Emission Monitoring Requirements |
| 58 | n/a | Appendix A to Part 58 - Quality Assurance Requirements for SLAMS, SPMs and PSD Air Monitoring |
| 60 | A | General Provisions [Except 60.4, 60.9, 60.10 and 60.16] |
| 60 | D | Standards of Performance for Fossil-Fuel-Fired Steam Generators |
| 60 | Da | Standards of Performance for Electric Utility Steam Generating Units |
| 60 | Db | Standards of Performance for Industrial-Commercial-Institutional Steam Generating Units |
| 60 | Dc | Standards of Performance for Small Industrial-Commercial-Institutional Steam Generating Units |
| 60 | E | Standards of Performance for Incinerators |
| 60 | Ea | Standards of Performance for Municipal Waste Combustors for Which Construction is Commenced After December 20, 1989 and on or Before September 20, 1994 |
| 60 | Eb | Standards of Performance for Large Municipal Waste Combustors for Which Construction is Commenced After September 20, 1994 or for Which Modification or Reconstruction is Commenced After June 19, 1996 |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 60 | Ec | Standards of Performance for Hospital/Medical/Infectious Waste Incinerators for Which Construction is Commenced After June 20, 1996 |
| 60 | F | Standards of Performance for Portland Cement Plants |
| 60 | G | Standards of Performance for Nitric Acid Plants |
| 60 | H | Standards of Performance for Sulfuric Acid Plants |
| 60 | I | Standards of Performance for Hot Mix Asphalt Facilities |
| 60 | J | Standards of Performance for Petroleum Refineries |
| 60 | Ja | Standards of Performance for Petroleum Refineries for Which Construction, Reconstruction, or Modification Commenced After May 14, 2007 |
| 60 | K | Standards of Performance for Storage Vessels for Petroleum Liquids for Which Construction, Reconstruction, or Modification Commenced After June 11, 1973, and Prior to May 19, 1978 |
| 60 | Ka | Standards of Performance for Storage Vessels for Petroleum Liquids for Which Construction, Reconstruction, or Modification Commenced After May 18, 1978, and Prior to July 23, 1984 |
| 60 | Kb | Standards of Performance for Volatile Organic Liquid Storage Vessels (Including Petroleum Liquid Storage Vessels) for Which Construction, Reconstruction, or Modification Commenced After July 23, 1984 |
| 60 | L | Standards of Performance for Secondary Lead Smelters |
| 60 | M | Standards of Performance for Secondary Brass and Bronze Production Plants |
| 60 | N | Standards of Performance for Primary Emissions from Basic Oxygen Process Furnaces for Which Construction is Commenced After June 11, 1973 |
| 60 | Na | Standards of Performance for Secondary Emissions from Basic Oxygen Process Steelmaking Facilities for Which Construction is Commenced After January 20, 1983 |
| 60 | O | Standards of Performance for Sewage Treatment Plants |
| 60 | P | Standards of Performance for Primary Copper Smelters |
| 60 | Q | Standards of Performance for Primary Zinc Smelters |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 60 | R | Standards of Performance for Primary Lead Smelters |
| 60 | S | Standards of Performance for Primary Aluminum Reduction Plants |
| 60 | T | Standards of Performance for the Phosphate Fertilizer Industry: Wet-Process Phosphoric Acid Plants |
| 60 | U | Standards of Performance for the Phosphate Fertilizer Industry: Superphosphoric Acid Plants |
| 60 | V | Standards of Performance for the Phosphate Fertilizer Industry: Diammonium Phosphate Plants |
| 60 | W | Standards of Performance for the Phosphate Fertilizer Industry: Triple Superphosphate Plants |
| 60 | X | Standards of Performance for the Phosphate Fertilizer Industry: Granular Triple Superphosphate Storage Facilities |
| 60 | Y | Standards of Performance for Coal Preparation and Processing Plants |
| 60 | Z | Standards of Performance for Ferroalloy Production Facilities |
| 60 | AA | Standards of Performance for Steel Plants: Electric Arc Furnaces Constructed After October 21, 1974, and On or Before August 17, 1983 |
| 60 | AAa | Standards of Performance for Steel Plants: Electric Arc Furnaces and Argon-Oxygen Decarburization Vessels Constructed After August 17, 1983 |
| 60 | BB | Standards of Performance for Kraft Pulp Mills |
| 60 | CC | Standards of Performance for Glass Manufacturing Plants |
| 60 | DD | Standards of Performance for Grain Elevators |
| 60 | EE | Standards of Performance for Surface Coating of Metal Furniture |
| 60 | GG | Standards of Performance for Stationary Gas Turbines |
| 60 | HH | Standards of Performance for Lime Manufacturing Plants |
| 60 | KK | Standards of Performance for Lead-Acid Battery Manufacturing Plants |
| 60 | LL | Standards of Performance for Metallic Mineral Processing Plants |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 60 | MM | Standards of Performance for Automobile and Light Duty Truck Surface Coating Operations |
| 60 | NN | Standards of Performance for Phosphate Rock Plants |
| 60 | PP | Standards of Performance for Ammonium Sulfate Manufacture |
| 60 | QQ | Standards of Performance for the Graphic Arts Industry: Publication Rotogravure Printing |
| 60 | RR | Standards of Performance for Pressure Sensitive Tape and Label Surface Coating Operations |
| 60 | SS | Standards of Performance for Industrial Surface Coating: Large Appliances |
| 60 | TT | Standards of Performance for Metal Coil Surface Coating |
| 60 | UU | Standards of Performance for Asphalt Processing and Asphalt Roofing Manufacture |
| 60 | VV | Standards of Performance for Equipment Leaks of VOC in the Synthetic Organic Chemicals Manufacturing Industry for which Construction, Reconstruction, or Modification Commenced After January 5, 1981, and on or Before November 7, 2006 |
| 60 | VVa | Standards of Performance for Equipment Leaks of VOC in the Synthetic Organic Chemicals Manufacturing Industry for Which Construction, Reconstruction, or Modification Commenced After November 7, 2006 |
| 60 | WW | Standards of Performance for the Beverage Can Surface Coating Industry |
| 60 | XX | Standards of Performance for Bulk Gasoline Terminals |
| 60 | BBB | Standards of Performance for the Rubber Tire Manufacturing Industry |
| 60 | DDD | Standards of Performance for Volatile Organic Compound (VOC) Emissions from the Polymer Manufacturing Industry |
| 60 | FFF | Standards of Performance for Flexible Vinyl and Urethane Coating and Printing |
| 60 | GGG | Standards of Performance for Equipment Leaks of VOC in Petroleum Refineries for which Construction, Reconstruction, or Modification Commenced After January 4, 1983, and on or Before November 7, 2006 |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 60 | GGGa | Standards of Performance for Equipment Leaks of VOC in Petroleum Refineries for Which Construction, Reconstruction, or Modification Commenced After November 7, 2006 |
| 60 | HHH | Standards of Performance for Synthetic Fiber Production Facilities |
| 60 | III | Standards of Performance for Volatile Organic Compound (VOC) Emissions From the Synthetic Organic Chemical Manufacturing Industry (SOCMI) Air Oxidation Unit Processes |
| 60 | JJJ | Standards of Performance for Petroleum Dry Cleaners |
| 60 | KKK | Standards of Performance for Equipment Leaks of VOC From Onshore Natural Gas Processing Plants for Which Construction, Reconstruction, or Modification Commenced After January 20, 1984, and on or Before August 23, 2011 |
| 60 | LLL | Standards of Performance for $SO_2$ Emissions From Onshore Natural Gas Processing: $SO_2$ Emissions for Which Construction, Reconstruction, or Modification Commenced After January 20, 1984, and on or Before August 23, 2011 |
| 60 | NNN | Standards of Performance for Volatile Organic Compound (VOC) Emissions From Synthetic Organic Chemical Manufacturing Industry (SOCMI) Distillation Operations |
| 60 | OOO | Standards of Performance for Nonmetallic Mineral Processing Plants |
| 60 | PPP | Standard of Performance for Wool Fiberglass Insulation Manufacturing Plants |
| 60 | QQQ | Standards of Performance for VOC Emissions From Petroleum Refinery Wastewater Systems |
| 60 | RRR | Standards of Performance for Volatile Organic Compound Emissions From Synthetic Organic Chemical Manufacturing Industry (SOCMI) Reactor Processes |
| 60 | SSS | Standards of Performance for Magnetic Tape Coating Facilities |
| 60 | TTT | Standards of Performance for Industrial Surface Coating: Surface Coating of Plastic Parts for Business Machines |
| 60 | UUU | Standards of Performance for Calciners and Dryers in Mineral Industries |
| 60 | VVV | Standards of Performance for Polymeric Coating of Supporting Substrates Facilities |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 60 | WWW | Standards of Performance for Municipal Solid Waste Landfills |
| 60 | AAAA | Standards of Performance for Small Municipal Waste Combustion Units for Which Construction is Commenced After August 30, 1999 or for Which Modification or Reconstruction is Commenced After June 6, 2001 |
| 60 | EEEE | Standards of Performance for Other Solid Waste Incineration Units for Which Construction Is Commenced After December 9, 2004, or for Which Modification or Reconstruction Is Commenced on or After June 16, 2006 |
| 60 | IIII | Standards of Performance for Stationary Compression Ignition Internal Combustion Engines |
| 60 | JJJJ | Standards of Performance for Stationary Spark Ignition Internal Combustion Engines |
| 60 | KKKK | Standards of Performance for Stationary Combustion Turbines |
| 60 | LLLL | Standards of Performance for New Sewage Sludge Incineration Units |
| 60 | OOOO | Standards of Performance for Crude Oil and Natural Gas Production, Transmission and Distribution |
| 60 | n/a | Appendix A to Part 60 - Test Methods |
| 60 | n/a | Appendix B to Part 60 - Performance Specifications |
| 61 | A | General Provisions |
| 61 | C | National Emission Standard for Beryllium |
| 61 | D | National Emission Standard for Beryllium Rocket Motor Firing |
| 61 | E | National Emission Standard for Mercury |
| 61 | F | National Emission Standard for Vinyl Chloride |
| 61 | J | National Emission Standard for Equipment Leaks (Fugitive Emission Sources) of Benzene |
| 61 | L | National Emission Standard for Benzene Emissions from Coke By-Product Recovery Plants |
| 61 | M | National Emission Standard for Asbestos |
| 61 | N | National Emission Standard for Inorganic Arsenic Emissions From Glass Manufacturing Plants |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 61 | O | National Emission Standard for Inorganic Arsenic Emissions From Primary Copper Smelters |
| 61 | P | National Emission Standard for Inorganic Arsenic Emissions From Arsenic Trioxide and Metallic Arsenic Production Facilities |
| 61 | V | National Emission Standard for Equipment Leaks (Fugitive Emission Sources) |
| 61 | Y | National Emission Standard for Benzene Emissions From Benzene Storage Vessels |
| 61 | BB | National Emission Standard for Benzene Emissions From Benzene Transfer Operations |
| 61 | FF | National Emission Standard for Benzene Waste Operations |
| 63 | A | General Provisions |
| 63 | B | Sections 63.41, 63.43 and 63.44 only of Subpart B, Requirements for Control Technology Determinations for Major Sources in Accordance With Clean Air Act Sections, Sections 112(g) and 112(j) |
| 63 | F | National Emission Standards for Organic Hazardous Air Pollutants From the Synthetic Organic Chemical Manufacturing Industry |
| 63 | G | National Emission Standards for Organic Hazardous Air Pollutants From the Synthetic Organic Chemical Manufacturing Industry for Process Vents, Storage Vessels, Transfer Operations, and Wastewater |
| 63 | H | National Emission Standards for Organic Hazardous Air Pollutants for Equipment Leaks |
| 63 | I | National Emission Standards for Organic Hazardous Air Pollutants for Certain Processes Subject to the Negotiated Regulation for Equipment Leaks |
| 63 | J | National Emission Standards for Hazardous Air Pollutants for Polyvinyl Chloride and Copolymers Production |
| 63 | L | National Emission Standards for Coke Oven Batteries |
| 63 | M | National Perchloroethylene Air Emission Standards for Dry Cleaning Facilities |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 63 | N | National Emission Standards for Chromium Emissions From Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks |
| 63 | O | Ethylene Oxide Emissions Standards for Sterilization Facilities |
| 63 | Q | National Emission Standards for Hazardous Air Pollutants for Industrial Process Cooling Towers |
| 63 | R | National Emission Standards for Gasoline Distribution Facilities (Bulk Gasoline Terminals and Pipeline Breakout Stations) |
| 63 | S | National Emission Standards for Hazardous Air Pollutants from the Pulp and Paper Industry |
| 63 | T | National Emission Standards for Halogenated Solvent Cleaning |
| 63 | U | National Emission Standards for Hazardous Air Pollutant Emissions: Group I Polymers and Resins |
| 63 | W | National Emission Standards for Hazardous Air Pollutants for Epoxy Resins Production and Non-Nylon Polyamides Production |
| 63 | X | National Emission Standards for Hazardous Air Pollutants from Secondary Lead Smelting |
| 63 | Y | National Emission Standards for Marine Tank Vessel Loading Operations |
| 63 | AA | National Emission Standards for Hazardous Air Pollutants From Phosphoric Acid Manufacturing Plants |
| 63 | BB | National Emission Standards for Hazardous Air Pollutants From Phosphate Fertilizers Production Plants |
| 63 | CC | National Emission Standards for Hazardous Air Pollutants From Petroleum Refineries |
| 63 | DD | National Emission Standards for Hazardous Air Pollutants from Off-Site Waste and Recovery Operations |
| 63 | EE | National Emission Standards for Magnetic Tape Manufacturing Operations |
| 63 | GG | National Emission Standards for Aerospace Manufacturing and Rework Facilities |
| 63 | HH | National Emission Standards for Hazardous Air Pollutants From Oil and Natural Gas Production Facilities |
| 63 | II | National Emission Standards for Shipbuilding and Ship Repair |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| | | (Surface Coating) |
| 63 | JJ | National Emission Standards for Wood Furniture Manufacturing Operations |
| 63 | KK | National Emission Standards for the Printing and Publishing Industry |
| 63 | LL | National Emission Standards for Hazardous Air Pollutants for Primary Aluminum Reduction Plants |
| 63 | MM | National Emission Standards for Hazardous Air Pollutants for Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-Alone Semichemical Pulp Mills |
| 63 | OO | National Emission Standards for Tanks - Level 1 |
| 63 | PP | National Emission Standards for Containers |
| 63 | QQ | National Emission Standards for Surface Impoundments |
| 63 | RR | National Emission Standards for Individual Drain Systems |
| 63 | SS | National Emission Standards for Closed Vent Systems, Control Devices, Recovery Devices and Routing to a Fuel Gas System or a Process |
| 63 | TT | National Emission Standards for Equipment Leaks – Control Level 1 |
| 63 | UU | National Emission Standards for Equipment Leaks - Control Level 2 Standards |
| 63 | VV | National Emission Standards for Oil-Water Separators and Organic-Water Separators |
| 63 | WW | National Emission Standards for Storage Vessels (Tanks) - Control Level 2 |
| 63 | XX | National Emission Standards for Ethylene Manufacturing Process Units: Heat Exchange Systems and Waste Operations |
| 63 | YY | National Emission Standards for Hazardous Air Pollutants for Source Categories: Generic Maximum Achievable Control Technology Standards |
| 63 | CCC | National Emission Standards for Hazardous Air Pollutants for Steel Pickling - HCl Process Facilities and Hydrochloric Acid Regeneration Plants |
| 63 | DDD | National Emission Standards for Hazardous Air Pollutants for Mineral Wool Production |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 63 | EEE | National Emission Standards for Hazardous Air Pollutants from Hazardous Waste Combustors |
| 63 | GGG | National Emission Standards for Pharmaceuticals Production |
| 63 | HHH | National Emission Standards for Hazardous Air Pollutants From Natural Gas Transmission and Storage Facilities |
| 63 | III | National Emission Standards for Hazardous Air Pollutants for Flexible Polyurethane Foam Production |
| 63 | JJJ | National Emission Standards for Hazardous Air Pollutant Emissions: Group IV Polymers and Resins |
| 63 | LLL | National Emission Standards for Hazardous Air Pollutants From the Portland Cement Manufacturing Industry |
| 63 | MMM | National Emission Standards for Hazardous Air Pollutants for Pesticide Active Ingredient Production |
| 63 | NNN | National Emission Standards for Hazardous Air Pollutants for Wool Fiberglass Manufacturing |
| 63 | OOO | National Emission Standards for Hazardous Air Pollutant Emissions: Manufacture of Amino/Phenolic Resins |
| 63 | PPP | National Emission Standards for Hazardous Air Pollutant Emissions for Polyether Polyols Production |
| 63 | QQQ | National Emission Standards for Hazardous Air Pollutants for Primary Copper Smelting |
| 63 | RRR | National Emission Standards for Hazardous Air Pollutants for Secondary Aluminum Production |
| 63 | TTT | National Emission Standards for Hazardous Air Pollutants for Primary Lead Smelting |
| 63 | UUU | National Emission Standards for Hazardous Air Pollutants for Petroleum Refineries: Catalytic Cracking Units, Catalytic Reforming Units, and Sulfur Recovery Units |
| 63 | VVV | National Emission Standards for Hazardous Air Pollutants: Publicly Owned Treatment Works |
| 63 | XXX | National Emission Standards for Hazardous Air Pollutants for Ferroalloys Production: Ferromanganese and Silicomanganese |
| 63 | AAAA | National Emission Standards for Hazardous Air Pollutants: Municipal Solid Waste Landfills |
| 63 | CCCC | National Emission Standards for Hazardous Air Pollutants: |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| | | Manufacturing of Nutritional Yeast |
| 63 | DDDD | National Emission Standards for Hazardous Air Pollutants: Plywood and Composite Wood Products |
| 63 | EEEE | National Emission Standards for Hazardous Air Pollutants: Organic Liquids Distribution (Non-Gasoline) |
| 63 | FFFF | National Emission Standards for Hazardous Air Pollutants: Miscellaneous Organic Chemical Manufacturing |
| 63 | GGGG | National Emission Standards for Hazardous Air Pollutants: Solvent Extraction for Vegetable Oil Production |
| 63 | HHHH | National Emission Standards for Hazardous Air Pollutants for Wet-Formed Fiberglass Mat Production |
| 63 | IIII | National Emission Standards for Hazardous Air Pollutants: Surface Coating of Automobiles and Light-Duty Trucks |
| 63 | JJJJ | National Emission Standards for Hazardous Air Pollutants: Paper and Other Web Coating |
| 63 | KKKK | National Emission Standards for Hazardous Air Pollutants: Surface Coating of Metal Cans |
| 63 | MMMM | National Emission Standards for Hazardous Air Pollutants for Surface Coating of Miscellaneous Metal Parts and Products |
| 63 | NNNN | National Emission Standards for Hazardous Air Pollutants: Surface Coating of Large Appliances |
| 63 | OOOO | National Emission Standards for Hazardous Air Pollutants: Printing, Coating, and Dyeing of Fabrics and Other Textiles |
| 63 | PPPP | National Emission Standards for Hazardous Air Pollutants for Surface Coating of Plastic Parts and Products |
| 63 | QQQQ | National Emission Standards for Hazardous Air Pollutants: Surface Coating of Wood Building Products |
| 63 | RRRR | National Emission Standards for Hazardous Air Pollutants: Surface Coating of Metal Furniture |
| 63 | SSSS | National Emission Standards for Hazardous Air Pollutants: Surface Coating of Metal Coil |
| 63 | TTTT | National Emission Standards for Hazardous Air Pollutants for Leather Finishing Operations |
| 63 | UUUU | National Emission Standards for Hazardous Air Pollutants for Cellulose Products Manufacturing |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 63 | VVVV | National Emission Standards for Hazardous Air Pollutants for Boat Manufacturing |
| 63 | WWWW | National Emissions Standards for Hazardous Air Pollutants: Reinforced Plastic Composites Production |
| 63 | XXXX | National Emissions Standards for Hazardous Air Pollutants: Rubber Tire Manufacturing |
| 63 | YYYY | National Emission Standards for Hazardous Air Pollutants for Stationary Combustion Turbines |
| 63 | ZZZZ | National Emission Standards for Hazardous Air Pollutants for Stationary Reciprocating Internal Combustion Engines |
| 63 | AAAAA | National Emission Standards for Hazardous Air Pollutants for Lime Manufacturing Plants |
| 63 | BBBBB | National Emission Standards for Hazardous Air Pollutants for Semiconductor Manufacturing |
| 63 | CCCCC | National Emission Standards for Hazardous Air Pollutants for Coke Ovens: Pushing, Quenching, and Battery Stacks |
| 63 | DDDDD | National Emission Standards for Hazardous Air Pollutants for Major Sources: Industrial, Commercial, and Institutional Boilers and Process Heaters |
| 63 | EEEEE | National Emission Standards for Hazardous Air Pollutants for Iron and Steel Foundries |
| 63 | FFFFF | National Emission Standards for Hazardous Air Pollutants for Integrated Iron and Steel Manufacturing Facilities |
| 63 | GGGGG | National Emission Standards for Hazardous Air Pollutants: Site Remediation |
| 63 | HHHHH | National Emission Standards for Hazardous Air Pollutants: Miscellaneous Coating Manufacturing |
| 63 | IIIII | National Emission Standards for Hazardous Air Pollutants: Mercury Emissions From Mercury Cell Chlor-Alkali Plants |
| 63 | JJJJJ | National Emission Standards for Hazardous Air Pollutants for Brick and Structural Clay Products Manufacturing |
| 63 | KKKKK | National Emission Standards for Hazardous Air Pollutants for Clay Ceramics Manufacturing |
| 63 | LLLLL | National Emission Standards for Hazardous Air Pollutants: Asphalt Processing and Asphalt Roofing Manufacturing |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 63 | MMMMM | National Emission Standards for Hazardous Air Pollutants: Flexible Polyurethane Foam Fabrication Operations |
| 63 | NNNNN | National Emission Standards for Hazardous Air Pollutants: Hydrochloric Acid Production |
| 63 | PPPPP | National Emission Standards for Hazardous Air Pollutants for Engine Test Cells/Stands |
| 63 | QQQQQ | National Emission Standards for Hazardous Air Pollutants for Friction Materials Manufacturing Facilities |
| 63 | RRRRR | National Emission Standards for Hazardous Air Pollutants: Taconite Iron Ore Processing |
| 63 | SSSSS | National Emission Standards for Hazardous Air Pollutants for Refractory Products Manufacturing |
| 63 | TTTTT | National Emission Standards for Hazardous Air Pollutants for Primary Magnesium Refining |
| 63 | UUUUU | National Emission Standards for Hazardous Air Pollutants: Coal and Oil-fired Electric Utility Steam Generating Units |
| 63 | WWWWW | National Emission Standards for Hospital Ethylene Oxide Sterilizers |
| 63 | YYYYY | National Emission Standards for Hazardous Air Pollutants for Area Sources: Electric Arc Furnace Steelmaking Facilities |
| 63 | ZZZZZ | National Emission Standards for Hazardous Air Pollutants for Iron and Steel Foundries Area Sources |
| 63 | BBBBBB | National Emission Standards for Hazardous Air Pollutants for Source Category: Gasoline Distribution Bulk Terminals, Bulk Plants, and Pipeline Facilities |
| 63 | CCCCCC | National Emission Standards for Hazardous Air Pollutants for Source Category: Gasoline Dispensing Facilities |
| 63 | DDDDDD | National Emission Standards for Hazardous Air Pollutants for Polyvinyl Chloride and Copolymers Production Area Sources |
| 63 | EEEEEE | National Emission Standards for Hazardous Air Pollutants for Primary Copper Smelting Area Sources |
| 63 | FFFFFF | National Emission Standards for Hazardous Air Pollutants for Secondary Copper Smelting Area Sources |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 63 | GGGGGG | National Emission Standards for Hazardous Air Pollutants for Primary Nonferrous Metals Area Sources - Zinc, Cadmium, and Beryllium |
| 63 | HHHHHH | National Emission Standards for Hazardous Air Pollutants: Paint Stripping and Miscellaneous Surface Coating Operations at Area Sources |
| 63 | JJJJJJ | National Emission Standards for Hazardous Air Pollutants for Industrial, Commercial, and Institutional Boilers Area Sources |
| 63 | LLLLLL | National Emission Standards for Hazardous Air Pollutants for Acrylic and Modacrylic Fibers Production Area Sources |
| 63 | MMMMMM | National Emission Standards for Hazardous Air Pollutants for Carbon Black Production Area Sources |
| 63 | NNNNNN | National Emission Standards for Hazardous Air Pollutants for Chemical Manufacturing Area Sources: Chromium Compounds |
| 63 | OOOOOO | National Emission Standards for Hazardous Air Pollutants for Flexible Polyurethane Foam Production and Fabrication Area Sources |
| 63 | PPPPPP | National Emission Standards for Hazardous Air Pollutants for Lead Acid Battery Manufacturing Area Sources |
| 63 | QQQQQQ | National Emission Standards for Hazardous Air Pollutants for Wood Preserving Area Sources |
| 63 | RRRRRR | National Emission Standards for Hazardous Air Pollutants for Clay Ceramics Manufacturing Area Sources |
| 63 | SSSSSS | National Emission Standards for Hazardous Air Pollutants for Glass Manufacturing Area Sources |
| 63 | TTTTTT | National Emission Standards for Hazardous Air Pollutants for Secondary Nonferrous Metals Processing Area Sources |
| 63 | VVVVVV | National Emission Standards for Hazardous Air Pollutants for Chemical Manufacturing Area Sources |
| 63 | WWWWWW | National Emission Standards for Hazardous Air Pollutants: Area Source Standards for Plating and Polishing Operations |
| 63 | XXXXXX | National Emission Standards for Hazardous Air Pollutants: Area Source Standards for Nine Metal Fabrication and Finishing Source Categories |
| 63 | YYYYYY | National Emission Standards for Hazardous Air Pollutants for Area Sources: Ferroalloys Production Facilities |

| PART | SUBPART | DESCRIPTION |
|---|---|---|
| 63 | ZZZZZZ | National Emission Standards for Hazardous Air Pollutants: Area Source Standards for Aluminum, Copper, and Other Nonferrous Foundries |
| 63 | AAAAAAA | National Emission Standards for Hazardous Air Pollutants for Area Sources: Asphalt Processing and Asphalt Roofing Manufacturing |
| 63 | BBBBBBB | National Emission Standards for Hazardous Air Pollutants for Area Sources: Chemical Preparations Industry |
| 63 | CCCCCCC | National Emission Standards for Hazardous Air Pollutants for Area Sources: Paints and Allied Products Manufacturing |
| 63 | DDDDDDD | National Emission Standards for Hazardous Air Pollutants for Area Sources: Prepared Feeds Manufacturing |
| 63 | EEEEEEE | National Emission Standards for Hazardous Air Pollutants: Gold Mine Ore Processing and Production Area Source Category |
| 63 | HHHHHHH | National Emission Standards for Hazardous Air Pollutants for Polyvinyl Chloride and Copolymers Production |
| 64 | n/a (All Sections) | Compliance Assurance Monitoring (CAM) |
| 72 | All Subparts | Permits Regulation |

*[OAR Docket #13-780; filed 5-16-13]*

## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 100. AIR POLLUTION CONTROL

*[OAR Docket #13-782]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 13. Open Burning
252:100-13-2 [AMENDED]
252:100-13-5 [AMENDED]
252:100-13-7 [AMENDED]
252:100-13-8 [NEW]
252:100-13-9 [AMENDED]
252:100-13-10 [AMENDED]
**AUTHORITY:**
Environmental Quality Board, 27A O.S. Sections 2-2-101 and 2-2-201; and Oklahoma Clean Air Act, 27A O.S. Sections 2-5-101 *et seq.*
**DATES:**
**Comment period:**
September 17, 2012 through November 14, 2012
December 17, 2012 through January 16, 2013
**Public hearing:**
November 14, 2012
January 16, 2013
February 22, 2013
**Adoption:**
February 22, 2013
**Submitted to Governor:**
February 27, 2013
**Submitted to House:**
February 27, 2013
**Submitted to Senate:**
February 27, 2013
**Gubernatorial approval:**
April 8, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on April 25, 2013
**Final adoption:**
April 25, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The Department is proposing to amend OAC 252:100-13, Open Burning, to modify the requirements for "air curtain incinerators" or "ACIs." Air curtain incinerators are combustion units that operate by forcefully projecting a curtain of air across an open, integrated combustion chamber (firebox) or an open pit or trench in which the combustion occurs. The proposed rulemaking would primarily affect the owners and operators of air curtain incinerators that are used on a temporary basis to burn trees, brush, and similar materials from land clearing, public health, safety, and disaster response activities. The affected entities include private as well as state, county, and municipal governmental entities. The Department is proposing changes to add flexibility in the operation of these units, including an extension of the allowed hours of operation. The existing rule requires land clearing operations in current and former nonattainment areas (Tulsa and Oklahoma Counties) to use ACIs. The proposal would expand this requirement to all counties in the Oklahoma City and Tulsa Metropolitan Statistical Areas. The Oklahoma City MSA comprises Canadian, Cleveland, Grady, Lincoln, Logan, McClain, and Oklahoma Counties, and the Tulsa MSA comprises Creek, Okmulgee, Osage, Pawnee, Rogers, and Tulsa Counties. The amendments also prohibit open burning in areas under an Ozone or Particulate Matter Watch. Additionally, the Department proposes to modify the rule to allow, under certain conditions, the transport of materials from the site where they are generated to the site where they would be burned.

**CONTACT PERSON:**
Cheryl Bradley, Department of Environmental Quality, Air Quality Division, 707 North Robinson, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, (405) 702-4100.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 13. OPEN BURNING

**252:100-13-2. Definitions**

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

**"Air curtain incinerator," "air curtain destructor,"** or **"open pit incinerator"** means an incineration unit operating by forcefully projecting a curtain of air across an open, integrated combustion chamber (fire box) or open pit or trench (trench burner) in which combustion occurs.

**"Clean lumber"** means wood or wood products that have been cut or shaped and include wet, air-dried, and kiln-dried wood products. Clean lumber does not include wood products that have been painted, pigment-stained, or pressure-treated by compounds such as chromate copper arsenate, pentachlorophenol, and creosote, or manufactured wood products that contain adhesives or resins (e.g., plywood, particle board, flake board, and oriented strand board).

**"Combustible materials"** means any substance which will readily burn and shall include those substances which, although generally considered incombustible, are or may be included in the mass of the material burned or to be burned.

**"Domestic refuse"** means combustible materials or refuse that normally result from the function of life at a residence, such as kitchen garbage, untreated lumber, cardboard boxes, packaging, clothing, grass, leaves, and branch trimmings. It does not include such things as tires, non-wood construction debris, furniture, carpet, electrical wire, and appliances.

**"Fire training"** means a fire purposely set as part of an organized program of drills for the training of firefighting personnel or for testing firefighting materials or equipment, which is part of a recognized training program.

**"Human-made structure"** means any structure constructed with the intent of providing shelter to persons or property. It does not include structures constructed specifically for live-burn fire training purposes.

**"Land clearing operation"** means the uprooting, cutting, or clearing of vegetation in preparation for the construction of buildings, the development of residential, commercial, agricultural, or industrial properties, and for the construction and maintenance of right-of-ways. It does not include the clearing of vegetation such as trimmings, fallen limbs, branches, or leaves, or other wastes from routine property maintenance

activities, or the removal or destruction of human-made structures.

**"Metropolitan Statistical Area" or "MSA"** means a core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core, as defined by the federal Office of Management and Budget.

**"Open burning"** means the burning of combustible materials in such a manner that the products of combustion are emitted directly to the outside atmosphere.

**"Ozone Watch"** means an announcement by the DEQ that the ozone concentrations in the watch area are forecasted to exceed the National Ambient Air Quality Standard. The Ozone Watch applies to the day following the announcement.

~~**"Open pit incinerator"** means a device consisting of a pit (into which the material to be combusted is placed) and nozzles, pipes, and other appurtenances designed and arranged in a manner to deliver additional air and/or auxiliary fuel to, or near, the zone of combustion so that theoretically complete combustion is accomplished or approached.~~

**"Particulate Matter Watch,"** or **"PM Watch"** means an announcement by the DEQ that the particulate matter concentrations in the watch area are forecasted to exceed the National Ambient Air Quality Standard. The PM Watch applies to the day following the announcement.

**"Products of combustion"** means all particulate and gaseous air contaminants emitted as a result of the burning of refuse and combustible materials.

**"Refuse"** means garbage, rubbish, domestic refuse and all other wastes generated by a trade, business, industry, building operation, or household.

**"Wood waste"** means untreated wood and untreated wood products, including tree stumps (whole or chipped), trees, tree limbs (whole or chipped), bark, sawdust, chips, scraps, slabs, millings, and shavings. Wood waste does not include:

(A) Grass, grass clippings, bushes, shrubs and clippings from bushes and shrubs from residential, commercial/retail, institutional, or industrial sources as part of maintaining yards or other private or public lands.

(B) Construction, renovation, or demolition wastes.

(C) Clean lumber.

(D) Treated wood and treated wood products, including wood products that have been painted, pigment-stained, or pressure treated by compounds such as chromate copper arsenate, pentachlorophenol, and creosote, or manufactured wood products that contain adhesives or resins (e.g., plywood, particle board, flake board, and oriented strand board).

**"Yard brush"** means cut or broken branches, leaves, limbs, shrubbery, or tree trimmings. It does not include refuse, grass clippings, in-ground tree stumps, or any non-vegetative material.

**252:100-13-5. Open burning prohibited**

The open burning of refuse and combustible materials is prohibited unless conducted in strict accordance with the conditions and requirements contained in OAC 252:100-13-7, 252:100-13-8, and 252:100-13-9. Except as allowed in 252:100-13-8 (1), no person shall accept any material owned by other persons nor transport combustible material from where it is generated to another location in order to perform open burning. Under no circumstances shall the open burning of tires be allowed.

**252:100-13-7. Allowed open burning**

When not prohibited by law or ordinance, the following types of burning are allowed, provided the conditions and requirements in OAC 252:100-13-9 have been met:

(1) **Fire training.** Open burning of human-made structures for the purpose of municipal fire department training is allowed as provided for in the Oklahoma Clean Air Act, 27A O.S., Section 2-5-106.1. Industrial and commercial facilities and fire training schools may conduct~~conducting~~ on-site live burn fire training ~~are not subject to this provision~~.

(2) **Elimination of hazards.** Provided prior authorization is obtained from the local fire chief, open burning is allowed for the elimination of:

(A) A fire hazard that cannot be abated by any other means.

(B) A dangerous or hazardous material when there is no other practical or lawful method of abatement or disposal, if authorization is also received from the DEQ prior to such burning.

(3) **Recreational and ceremonial fires.** Open burning is allowed for camp fires and other fires used solely for recreational purposes, ceremonial occasions, or non-commercial preparation of food.

(4) **Land management and land clearing operations.** Open burning is allowed for the following land management and land clearing operations~~.~~:

(A) Fires purposely set to forest, crop, or range lands for a specific reason in the management of forests, crops, or game, in accordance with practices recommended by the Oklahoma Department of Wildlife Conservation, the Oklahoma ~~State~~ Department of Agriculture, Food, and Forestry, and the United States Forest Service.

(B) Fires purposely set for land clearing operations if conducted at least 500 feet upwind of any occupied residence other than those located on the property on which the burning is conducted.~~, except that such burning must be conducted in open pit incinerators in counties or areas that are or have been designated nonattainment.~~ Such burning shall be conducted using an air curtain incinerator in counties or areas that are or have been designated nonattainment, or in the two MSAs with a population of greater than nine hundred thousand.The Oklahoma City MSA consists of Canadian, Cleveland, Grady, Lincoln, Logan, McClain, and Oklahoma Counties.The Tulsa

MSA consists of Creek, Okmulgee, Osage, Pawnee, Rogers, Tulsa, and Wagoner Counties.

(5) **Burning of domestic refuse.** Where no collection and disposal service is reasonably available, domestic refuse may be burned on the property where the waste is generated.

(6) **Hydrocarbon burning.** Open burning of hydrocarbons is allowed for:

(A) The disposal of spilled hydrocarbons or the waste products of oil exploration, development, refining, or processing operations which cannot be feasibly recovered or otherwise disposed of in a legal manner. Notice must be given to the DEQ prior to such burning.

(B) The disposal of waste hydrocarbons through a flare. The owner or operator shall be required to use a smokeless flare if a condition of air pollution is determined to exist by the DEQ.

(7) ~~**Open pit incinerator.** Except for hazardous material, any combustible material or refuse that is allowed to be burned under this Subchapter may be burned in an open pit incinerator that is properly designed and operated for the control of smoke and particulate matter. The owner or operator of the open pit incinerator shall not accept any material owned by other persons and shall not transport any material to the property where the open pit incinerator is located in order to burn the material.~~

~~(8)~~ **Yard brush.** Yard brush may be burned on the property where the waste is generated.

**252:100-13-8. Use of air curtain incinerators**

Except for hazardous material, any combustible material or refuse that is allowed to be burned under this Chapter may be burned in an air curtain incinerator that is properly designed and operated for the control of smoke and particulate matter. The owner or operator of an air curtain incinerator shall not accept any material owned by other persons and shall not transport any material to the property where the air curtain incinerator is located in order to burn the material, except as provided in OAC 252:100-13-8 (1).

(1) The owner or operator of the air curtain incinerator may accept and/or transport:

(A) 100 percent wood waste,

(B) 100 percent clean lumber, or

(C) 100 percent mixture of wood waste and clean lumber.

(2) In addition to the requirements in this subchapter, the owner or operator of the air curtain incinerator must comply with the requirements of OAC 252:100-17 and 40 CFR Part 60.

**252:100-13-9. General conditions and requirements for allowed open burning**

The open burning of refuse and other combustible material may be conducted only if the following conditions and requirements are met:

(1) No public nuisance is or will be created.

(2) The burning is controlled so that a visibility hazard is not created on any roadway, rail track or air field as a result of the air contaminants being emitted.

(3) The burning is conducted so that the contaminants do not adversely affect the ambient air quality of a city or town.

(4) The initial burning shall begin only between three hours after sunrise and three hours before sunset and additional fuel shall not be intentionally added to the fire at times outside these limits. This requirement does not apply to the open burning allowed under OAC 252:100-13-7(2), (3), (4)(A), ~~and~~ (6)(B), and 252:100-13-8.

(5) An Ozone or PM Watch has not been declared for the day of the burn for the MSA or county in which the burn is to be performed. This requirement does not apply to the open burning allowed under 252:100-13-7(2), (3), and (6)(B).

**252:100-13-10. Disaster relief**

Notwithstanding the prohibition in OAC 252:100-13-5, the Executive Director of the DEQ may allow the open burning of debris resulting from a disaster if the Executive Director determines such burning is necessary to protect public health and safety. Such approval, if granted, shall be accompanied by appropriate guidelines for burning the debris.

*[OAR Docket #13-782; filed 5-16-13]*

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## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
## CHAPTER 100. AIR POLLUTION CONTROL

*[OAR Docket #13-781]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 25. Visible Emissions and Particulates
252:100-25-5. [AMENDED]
Subchapter 31. Control of Emission of Sulfur Compounds
Part 5. New Equipment Standards
252:100-31-25. [AMENDED]
**AUTHORITY:**
Environmental Quality Board, 27A O.S. Sections 2-2-101 and 2-2-201; and Oklahoma Clean Air Act, 27A O.S. Sections 2-5-101 *et seq.*
**DATES:**
**Comment period:**
June 15, 2012 through July 18, 2012
September 17, 2012 through November 14, 2012
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April 8, 2013
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Failure of the Legislature to disapprove the rules resulted in approval on April 30, 2013
**Final adoption:**
April 30, 2013
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**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The Department is proposing to move an existing continuous opacity monitoring requirement from OAC 252:100-31, Control of Emission of Sulfur Compounds, to 252:100-25, Visible Emissions and Particulates, which is a more appropriate location. The proposal is not intended to add any additional requirements for facilities subject to either subchapter. However, the existing language of 252:100-25-5 has been modified to accommodate the change, to clarify the requirements and applicability, and to remove certain provisions that no longer apply.
**CONTACT PERSON:**
Cheryl Bradley, Department of Environmental Quality, Air Quality Division, 707 North Robinson, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, (405) 702-4100.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 25. VISIBLE EMISSIONS AND PARTICULATES

### 252:100-25-5. Continuous emission monitoring for opacity

(a) ~~Continuous monitoring of opacity is required for~~Owners or operators of the listed emission sources shall install, calibrate, operate, and maintain all monitoring equipment necessary for continuously monitoring opacity. These requirements apply to:

(1) fluid bed catalytic cracking unit catalyst regenerators at petroleum refineries as specified in paragraph 2.4 of 40 CFR Part 51, Appendix P,~~and~~

(2) fossil fuel-fired steam generators as specified in paragraph 2.1 of ~~in accordance with~~ 40 CFR Part 51, Appendix P, and~~which is hereby incorporated by reference as it existed on July 1, 1998.~~

(3) any fuel-burning equipment with a design heat input value of 250 MMBTU/hr or more that does not burn gaseous fuel exclusively, and that was not in being on or before July 1, 1972 or that is modified after July 1, 1972.

(b) ~~Owners or operators of these emission sources shall:~~

~~(1) Install, calibrate, operate, and maintain all monitoring equipment necessary for continuously monitoring opacity.~~

~~(2) Complete the installation and performance tests of such equipment and begin monitoring and recording by January 1, 2001.~~

~~(c)~~ This section shall not apply to~~:~~

~~(1) Sources already~~ such emission sources that are subject to a new source performance standard promulgated in 40 CFR Part 60 pursuant to section 111 of the Clean Air Act.

~~(2) Sources scheduled for retirement within 5 years after the effective date of this rule, provided adequate evidence and guarantees are available to show the source will cease operations prior to such date.~~

(~~d~~c) Required emission monitoring systems shall be installed, calibrated, operated, and maintained in accordance with 40 CFR Part 60, Appendix B, and 40 CFR Part 51, Appendix P. Alternative monitoring requirements different from the provisions of Parts 1 through 5 of Appendix P may be approved by the DEQ ~~and EPA~~ on a case-by-case basis if continuous monitoring cannot be implemented by a source due to physical plant limitations or extreme economic reasons. ~~For example, the following alternative monitoring requirements may be used for natural gas-fired facilities that burn oil on an emergency basis only (including periodic system testing not to exceed 40 hours per calendar year):~~

~~(1) A Certified Visible Emission Evaluator shall read visual emissions once per day when fuel oils are burned.~~

~~(2) Visual emissions readings shall be conducted in accordance with EPA Test Method 9 (40 CFR Part 60, Appendix A).~~

~~(3) Records of fuel oil burned (including type, amount, and duration burned) and visible emissions read shall be maintained for 2 years.~~

## SUBCHAPTER 31. CONTROL OF EMISSION OF SULFUR COMPOUNDS

## PART 5. NEW EQUIPMENT STANDARDS

### 252:100-31-25. Requirements for new fuel-burning equipment

Any fuel-burning equipment that was not in being on or before July 1, 1972 or that is modified after July 1, 1972 shall comply with the following requirements.

(1) **Emission limits.** Emissions of $SO_2$ attributable to the burning of fuel by fuel-burning equipment shall meet the following limits.

(A) **Gaseous fuel.** Emissions of $SO_2$ from combustion of natural gas or other gaseous fuel in fuel-burning equipment shall not exceed 0.2 lb/MMBTU heat input (86 ng/J).

(B) **Liquid fuel.** Emissions of $SO_2$ from combustion of liquid fuel in fuel-burning equipment shall not exceed 0.8 lb/MMBTU heat input (340 ng/J).

(C) **Solid fuel.** Emissions of $SO_2$ from combustion of solid fuel in fuel-burning equipment shall not exceed 1.2 lb/MMBTU heat input (520 ng/J).

(D) **Combination of fuels burned.** When different types of fuels are burned simultaneously in any combination, emissions of $SO_2$ shall not exceed the

applicable limit determined by proration unless a secondary fuel is used in de minimis quantities (less than five percent (5%) of total BTU heat input annually). The applicable limit, in lb/MMBTU heat input, shall be determined using the following formula, where X is the percent of total heat input derived from gaseous fuel, Y is the percent of total heat input derived from liquid fuel, and Z is the percent of total heat input derived from solid fuel:

$SO_2$ limit = (0.2X + 0.8Y + 1.2Z)/(X + Y + Z).

(2) **Averaging time.** The averaging time for the emission limits set in OAC 252:100-31-25(1) is three (3) hours unless a solid fuel sampling and analysis method is used to determine emission compliance. In that case the averaging time is 24 hours.

(3) **Additional requirements for sources with heat input of 250 MMBTU/hr or more.** Any fuel-burning equipment with design heat input values of 250 MMBTU/hr or more shall comply with the following requirements.

(A) **Sulfur dioxide emissions ~~Emission~~ monitoring.**

(i) ~~Opacity. A photoelectric or other type smoke detector and recorder shall be used to monitor opacity, except where gaseous fuel is the only fuel burned.~~

~~(ii)~~ ~~**Sulfur dioxide.**~~ The owner or operator shall install, calibrate, maintain, and operate a continuous $SO_2$ emissions monitoring system, except where:

(I) gaseous fuel containing less than 0.1% by weight sulfur (0.29 gr/scf or approximately 500 ppmv at standard conditions on a dry basis) is the only fuel burned; or

(II) a solid or liquid fuel sampling and analysis method is used to determine $SO_2$ emission compliance.

(~~iii~~ii) ~~**Installation, calibration, maintenance, and operation of emission monitoring systems.**~~ Required emission monitoring systems shall be installed, calibrated, maintained, and operated in accordance with 40 CFR Part 60, Appendix B, and 40 CFR Part 51, Appendix P.

(B) **Fuel monitoring.** The sulfur content of solid or liquid fuels as burned shall be determined in accordance with methods previously approved by the Director or in accordance with Method 19 of 40 CFR Part 60, Appendix A.

(C) **Recordkeeping.** The owner or operator shall maintain records of all measurements required in (A) and (B) of this subsection in accordance with the applicable requirements of OAC 252:100-43-7, including compliance status records and excess emissions measurements.

(4) **Alternative fuel.** The requirements of this section apply to any fuel-burning equipment that uses an alternative fuel, unless another limit representing BACT or equivalent is specified in the source's permit. Use of an alternative fuel in fuel-burning equipment is allowed, provided its use is authorized under an enforceable permit. Use of an alternative fuel in fuel-burning equipment is subject to any applicable restrictions or prohibitions that may exist in other provisions of state or federal statutes or rules, e.g., OAC 252:100-8-32.1, 252:100-31-7, 252:100-42, and/or 40 CFR Parts 60, 61, and/or 63.

*[OAR Docket #13-781; filed 5-16-13]*

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## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 515. MANAGEMENT OF SOLID WASTE

*[OAR Docket #13-778]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
252:515-1-2 [AMENDED]
Subchapter 19. Operational Requirements
252:515-19-50 [NEW]
**AUTHORITY:**
Environmental Quality Board powers and duties, 27A O.S. § 2-2-101, Solid Waste Management Advisory Council powers and duties, 27A O.S.§ 2-2-201 and Solid Waste Management Act, 27A O.S.§ 2-10-101, *et seq.* and § 2-10-801.2.
**DATES:**
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July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATION BY REFERENCE:**
N/A
**ANALYSIS:**
The Department is proposing to amend OAC 252:515-1-2 to exempt from the definition of "Land Disposal Facility" roofing material recycling facilities and used tire recycling facilities. The Department is also proposing to add a new OAC 252:515-19-50 in response to recent legislative changes to 27A O.S.§ 10-801.2, pertaining to exterior and interior slopes.
**CONTACT PERSON:**
Mike Stickney, Land Protection Division, Solid Waste Compliance Section, P.O. Box 1677, Oklahoma City, OK 73101-1677, e-mail at mike.stickney@deq.ok.gov, phone 405-702-5184, or fax 405-702-5101.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED**

**FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

**252:515-1-2. Definitions**

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise. Any term not defined in this Chapter shall be defined as set forth in OAC 252:515-1-3.

**"Active"** means, when used to describe a solid waste disposal facility or a portion thereof (e.g., active MSWLF or active cell), any solid waste disposal facility, or portion thereof, accepting solid waste as of the effective date of this Chapter, regardless of whether such facility has obtained a solid waste permit from DEQ.

**"Active life"** means the period of operation beginning with the initial receipt of solid waste and ending at completion of closure activities.

**"Active portion"** means:

(A) that part of a land disposal facility that has or is receiving waste and that has not received either intermediate or final cover; or

(B) solid waste process and storage areas at non-land disposal facilities.

**"Airport"** means a public-use airport open to the public without prior permission, and without restrictions within the physical capacities of available facilities.

**"Applicant"** means any person who applies for a new permit or a modification to an existing permit for a solid waste disposal facility identified in OAC 252:515-3-1(a) and (b).

**"Aquifer"** means a geological formation, group of formations, or portion of a formation capable of yielding significant quantities of groundwater to wells or springs.

**"Areas susceptible to mass movement"** means those areas of influence (i.e., areas characterized as having an active or substantial possibility of mass movement) where the movement of earth material at, beneath, or adjacent to the land disposal facility, because of natural or man-induced events, results in the downslope transport of soil and rock material by means of gravitational influence. Such areas include, but are not limited to, landslides, avalanches, debris slides and flows, soil fluxion, block sliding, and rock fall.

**"ASTM"** means the American Society for Testing and Materials.

**"Bird hazard"** means an increase in the likelihood of bird/aircraft collisions that may cause damage to the aircraft or injury to its occupants.

**"Buffer zone"** means a designated waste-free area within the permit boundary of a disposal facility, to separate waste handling, processing, and/or disposal activities from adjacent areas.

**"Citizen collection station"** means a designated location that is established or sponsored by a governmental entity and equipped with waste receptacles for exclusive, non-commercial use by individual residents to deposit their own household waste for collection and transportation to a permitted disposal site.

**"CLIMOCS"** means the following publication of the Oklahoma Climatological Survey: Shafer, Mark A., CLIMOCS: A Climatological Summary of 168 Oklahoma Cooperative Stations, Oklahoma Climatological Survey, February 1993, 184 pp.

**"Composite liner"** means a system installed at a land disposal facility composed of a recompacted clay liner overlain with a flexible membrane liner.

**"C&D landfill"** means a construction/demolition landfill.

**"Composting facility"** means a facility in which material is converted, under thermophilic conditions, to a product with a high humus content for use as a soil amendment or to prevent or remediate pollutants in soil, air, and stormwater run-off.

**"Construction/demolition waste"** means waste composed of the following:

(A) asbestos-free waste from construction and/or demolition projects that may include such materials as metal, concrete, brick, asphalt, glass, roofing materials, limited amounts of packing materials, sheetrock, or lumber;

(B) wood waste that may include such materials as yard waste, lumber, wood chips, wood shavings, sawdust, plywood, tree limbs, or tree stumps;

(C) yard waste that may include such materials as grass clippings, tree limbs, tree stumps, shrubbery, flowers, or other vegetative matter resulting from land clearing or landscaping operations; or

(D) residential lead-based paint waste.

**"Contaminated stormwater"** means:

(A) water such as leachate and gas collection condensate, or stormwater that has come into direct contact with solid waste or waste handling and/or treatment areas;

(B) stormwater discharged from areas of a land disposal facility with less than six inches of waste-free, compacted earthen material; or

(C) wastewater resulting from washing vehicles or areas that are or have been in direct contact with solid waste.

**"DEQ"** means the Oklahoma Department of Environmental Quality.

**"Disease vector"** means rodents, flies, mosquitoes, or other animals, including insects, capable of transmitting disease to humans.

**"Displacement"** means the relative movement of any two sides of a fault measured in any direction.

**"Disposal"** means the final disposition of waste and shall be taken to include any discharge, deposit, injection, dumping, spilling, leaking, or placing of waste into or on the land or water so that the waste or any constituent thereof may enter the environment, including the air and any surface waters or ground waters.

**"Disposal area"** means that part of a land disposal facility where waste is disposed.

**"Disposal facility"** means disposal site as defined at 27A O.S.§ 2-10-103.

**"Engineer"** means a licensed, professional engineer.

**"EPA"** means the United States Environmental Protection Agency.

**"Existing"** means, when used to describe a solid waste disposal facility or portion thereof (e.g. existing MSWLF or existing cell), any solid waste disposal facility, or portion thereof, that had a solid waste permit as of the effective date of this Chapter.

**"Facility"** means all contiguous land and structures, other appurtenances, and improvements on the land used for the handling, processing, storage, and/or disposal of solid waste.

**"Fault"** means a fracture or a zone of fractures in any material along which strata on one side have been displaced with respect to that on the other side.

**"Final closure"** means a disposal facility has permanently ceased to accept solid waste for disposal and all required closure activities have been completed for the entire facility in accordance with the approved closure plan. Final closure is not synonymous with phased closure.

**"Flood"** means the general and temporary condition of partial or complete inundation of normally dry land areas from the overflow of a lake, stream, river or other body of surface water, or the unusual and rapid accumulation or runoff of surface waters from any source.

**"Flood, One hundred year (100 year)"** means a flood that has a one percent or greater chance of occurrence in any given one year period, or of a magnitude equaled or exceeded once in 100 years on the average over a significantly long period.

**"Flood plain"** means the lowland and relatively flat areas adjoining inland waters that are inundated by the 100-year flood.

**"Gas condensate"** means the liquid generated as a result of gas recovery processes.

**"Generator"** means, in the context of NHIW, any person, by site, whose act or process produces NHIW, or whose act first causes an NHIW to become subject to regulation.

**"Groundwater"** means water below the land surface in a zone of saturation.

**"Hazardous waste"** means those wastes subject to regulation under OAC 252:205.

**"HBV"** means hepatitis B virus.

**"HIV"** means human immunodeficiency virus.

**"Holocene"** means the most recent epoch of the Quaternary period, extending from the end of the Pleistocene Epoch to the present.

**"Household hazardous waste"** means household waste that is corrosive, toxic, ignitable, or reactive, including, but not limited to: freon-containing appliances or tanks; non-empty propane tanks; oil, antifreeze, and other motor vehicle fluids; gasoline, kerosene, or diesel fuel; liquid paints; solvents; pesticides, herbicides, fungicides, or rodenticides; caustic cleaners; lead-acid batteries; swimming pool chemicals; unused firearm rounds; and acids and bases.

**"Household waste"** means any solid waste (including garbage, trash, and sanitary waste in septic tanks) derived from households (including single and multiple residences, hotels and motels, bunkhouses, ranger stations, crew quarters, campgrounds, picnic grounds, and day-use recreation areas).

**"Injection well"** means a facility subject to regulation by OAC 252:652, Underground Injection Control.

**"Karst terrains"** means areas where karst topography, with its characteristic surface and subterranean features, is developed as the result of dissolution of limestone, dolomite, or other soluble rock. Characteristic features of karst terrains include, but are not limited to, sinkholes, sinking streams, caves, large springs, and blind valleys.

**"Land disposal facility"** means a landfill, or any other discrete area of land or land excavation, where solid waste is placed for treatment, processing, and/or disposal. Land disposal facility does not include:

(A) land application where solid waste is placed onto, or incorporated into, the soil as a soil amendment, fertilizer, or other legitimate agricultural purpose;

(B) a surface impoundment that is either permitted by DEQ's Water Quality Division or is a part of an approved liquid waste management system at a permitted solid waste disposal facility;

(C) a yard waste composting facility;

(D) an injection well; ~~or~~

(E) a solid waste transfer station;

(F) a Used Tire Recycling Facility; or

(G) a Roofing Material Recycling Facility

## SUBCHAPTER 19. OPERATIONAL REQUIREMENTS

## PART 5. COVER AND SOIL BORROW REQUIREMENTS FOR LAND DISPOSAL FACILITIES

**252:515-19-50. Slope limits**

(a) **Interior slopes.** The slope of a waste disposal area shall be no steeper overall than 3 horizontal to 1 vertical (3:1) at any time when it adjoins an area within the permitted boundary proposed to accept waste.

(b) **Exterior slopes.** The slope of a waste disposal area shall be no steeper overall than 4 horizontal to 1 vertical (4:1) at any time when located at the limits of the permitted boundary or adjoining an area not proposed to accept waste.

(c) **Working face.** The slope of the working face may vary during daily placement of waste but shall be graded to meet applicable slope requirements in (a) or (b) of this paragraph at the end of each operating day.

(d) **Slope correction.** A plan shall be submitted to DEQ within sixty (60) days of a determination that one or more slopes exceed the limits specified in this Section. The plan will specify tasks and the timeline needed to achieve compliance with this Section. Failure to submit a plan within the time specified by DEQ may result in the initiation of the Administrative Enforcement Process. Failure to follow or maintain the

plan submitted to DEQ may also result in the initiation of the Administrative Enforcement Process.

*[OAR Docket #13-778; filed 5-16-13]*

## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 515. MANAGEMENT OF SOLID WASTE

*[OAR Docket #13-777]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 41. Roofing Material Recycling [NEW]
252:515-41-1 [NEW]
252:515-41-2 [NEW]
252:515-41-3 [NEW]
252:515-41-4 [NEW]
252:515-41-5 [NEW]
252:515-41-6 [NEW]
252:515-41-7 [NEW]
252-515-41-8 [NEW]
252:515-41-9 [NEW]
252:515-41-10 [NEW]
252:515-41-11 [NEW]
252:515-41-12 [NEW]
252:515-41-14 [NEW]
252:515-41-15 [NEW]
252:515-41-16 [NEW]
**AUTHORITY:**
Environmental Quality Board powers and duties, 27A O.S. § 2-2-101, Solid Waste Management Advisory Council powers and duties, 27A O.S. § 2-2-201 and the Oklahoma Solid Waste Management Act, § 27A O.S. § 2-10-101, *et seq.* and § 2-10-802.2.
**DATES:**
**Comment period:**
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATION BY REFERENCE:**
N/A
**ANALYSIS:**
The Department is proposing to amend OAC 252:515 by adding a new Subchapter 41 in response to recent legislative changes to 27A O.S. § 2-10-802.2, relating to Roofing Material Recycling Facilities.
**CONTACT PERSON:**
Mike Stickney, Land Protection Division, Solid Waste Compliance Section, P.O. Box 1677, Oklahoma City, OK 73101-1677, e-mail at mike.stickney@deq.ok.gov, phone 405-702-5184, or fax 405-702-5101.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 41. ROOFING MATERIAL RECYCLING

**252:515-41-1. Purpose, authority, and applicability**

(a) **Purpose.** The purpose of this Subchapter is to implement and enforce the Roofing Material Recycling amendments to the Oklahoma Solid Waste Management Act. The rules in this Subchapter are to provide for the implementation of and a fee structure for roofing material recycling facilities.

(b) **Authority.** OAC 252:515-41-1 through 515-41-16 is authorized by 27A O.S.§ 2-10-802.2.

(c) **Applicability.** The rules in this Subchapter apply to roofing material recycling facilities.

**252:515-41-2. Definitions**

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

**"Disposal site"** means any place, including, but not limited to, a transfer station or a roofing material recycling facility, at which solid waste is dumped, abandoned, or accepted or disposed of by incineration, land filling, composting, shredding, compaction, baling or any other method or by processing by pyrolysis, resource recovery or any other method, technique or process designed to change the physical, chemical or biological character or composition of any solid waste so as to render such waste safe or nonhazardous, amenable to transport, recovery or storage or reduced in volume. A disposal site shall not include a manufacturing facility which processes scrap materials which have been separated for collection and processing as industrial raw materials.

**"Roofing Material"** means all material associated with a roofing project that is debris or is otherwise not intended for future use by the roofer or the property owner, including but not limited to shingles made from asphalt, fiberglass, composite, or wood, as well as decking, flashing, fasteners, insulation, and associated packaging materials.

**"Roofing material recycling facility"** means a site or facility at which roofing material is processed for alternative uses, or is accumulated for the purpose of processing or selling all or parts of the roofing material for alternative uses, including but not limited to road construction.

**252:515-41-3. Permit requirements**

All roofing material recycling facilities are subject to the requirements of this Subchapter and require a solid waste permit from DEQ prior to construction and/or operation.

**252:515-41-4. Prohibition**

Except as provided in OAC 252:515-41-3, no person shall dispose of roofing material at any roofing material recycling facility for which a solid waste permit has not been issued by DEQ.

**252:515-41-5. Duration of permit**

(a) **Life of site.** Permits shall be issued for the life of the roofing material recycling facility.

(b) **Cessation of operations.** If a permitted roofing material recycling facility ceases to accept roofing material for 30 days or more without prior notice to DEQ, the roofing material recycling facility will be deemed to be in the process of final closure and shall begin closure activities.

**252:515-41-6. Permit transfer**

(a) **Transfer required.** If the ownership of a roofing material recycling facility is assumed by a new entity, the permit must be transferred from the previous owner/operator ("transferor") to the new owner/operator ("transferee").

(b) **Exception.** Changes in corporate ownership from majority stock transfers do not require a permit transfer. However, such changes require notice to DEQ and submittal of an approved disclosure statement meeting the requirements of OAC 252:515-3-31(g).

(c) **Transfer requirements.** Permits may be transferred from the transferor to the transferee upon the following conditions:

(1) the transferor has submitted a written request to DEQ for transfer of the permit to the transferee;

(2) the transferee has submitted an approved disclosure statement meeting the requirements of OAC 252:515-3-31(g);

(3) the transferee has, if required, established an approved financial assurance mechanism in an appropriate amount and appropriately funded;

(4) the transferee has agreed in writing to comply with:

(A) all permit conditions;

(B) approved plans and specifications;

(C) the Oklahoma Solid Waste Management Act;

(D) the rules in this Chapter; and

(E) any final orders issued pursuant thereto;

(5) the transferee has complied with OAC 252:515-3-33 (relating to oath required); and

(6) the facility meets the compliance requirements of OAC 252:4-7-15. In lieu of demonstrating substantial compliance, the parties to the transfer may enter into a Consent Order with DEQ to schedule compliance.

(d) **Transferor responsible.** Until such time as DEQ approves transfer of the permit to the transferee, the transferor shall remain responsible for the operation of the facility.

**252:515-41-7. Permit applications and requirements**

(a) **All permit applications.** All permit applications are subject to the Oklahoma Uniform Environmental Permitting Act as well as the requirements of this Subchapter.

(b) **New permit applications.** Applicants requesting a permit for a new roofing material recycling facility shall submit a permit application to DEQ meeting the requirements of this Subchapter.

(c) **Modifications required.**

(1) The permit must be modified before making any changes to the approved design, construction, or operation of the facility.

(2) The modification application shall contain any maps, drawings, plans or other documents identified in this Subchapter to ensure the modification will be in compliance with the applicable requirements of this Chapter.

(d) **Administrative correction.** DEQ may make administrative corrections to the permit.

(e) **Tier I and II permit modifications.** Applicants requesting a Tier I or Tier II modification of an existing permit shall submit a permit modification application to DEQ meeting the applicable requirements of this Subchapter, but are not required to comply with OAC 252:515-3-33 (relating to oath required), unless otherwise required by statute.

(f) **Tier III permit modifications.** Applicants requesting a Tier III modification of an existing permit shall submit a permit modification application to DEQ meeting the applicable requirements of this Subchapter, and comply with OAC 252:515-3-33.

(g) **Disclosure statement.** Persons submitting a permit application for a new roofing material recycling facility, or the transfer of an existing roofing material recycling permit, are subject to the disclosure statement requirements of 27A O.S.§§ 2-10-103 and 2-10-302.

**252:515-41-8. Variance from the rules of this Chapter**

(a) **Application.** Except as provided for in (c) of this Section, applicants may, in a permit application, request a variance from one or more provisions of this Chapter in accordance with 27A O.S.§ 2-10-304.

(b) **Technical considerations.** Applicants requesting a variance must demonstrate that operations under the variance will equal or exceed the protection accorded by the particular rule for which the variance is being requested, and will not result in a hazard to the health, environment, or safety of the people of this State or their property.

**252:515-41-9. Oath required**

The applicant shall sign the permit application under oath on forms provided by DEQ.

**252:515-41-10. Legal right to property**

(a) **Right of access.** The permit application for a new roofing material recycling facility, or expansion of the permit boundaries of an existing roofing material recycling facility, must contain:

(1) a true and correct copy of a legal document filed in the county in which the facility is located, demonstrating that the applicant possesses a legal right to access and use the property in the manner for which the permit is sought,

including any on- or off-site soil borrow areas, throughout the life of the site; and

(2) a certification, by affidavit, that the applicant owns the real property, has a current lease or easement which is given to accomplish the permitted purpose, or has provided legal notice to the landowner.

(b) **Option for use.** If an option for right of access is predicated upon the issuance of a permit prior to the exercise of that option, then the applicant must submit a copy of the option with the permit application. Once the permit has been issued, the applicant must comply with (a) of this Section prior to beginning construction.

(c) **Easement to DEQ.** Unless the property owner is a unit of government, a temporary easement shall be executed allowing DEQ and/or its contractors the right to access the property to perform closure, post-closure monitoring, or corrective action in the event of default by the owner/operator.

**252:515-41-11. Permit applications**

(a) **New applications.** A permit application for a new roofing material recycling facility shall include all information required by the Oklahoma Uniform Environmental Permitting Act, including:

(1) the owner/operator's name, mailing address, and phone number;

(2) the name by which the facility will be known, the mailing address of the facility, the street address of the facility (if different from the mailing address), and the facility phone number;

(3) a disclosure statement completed in accordance with OAC 252:515-3-31(g);

(4) a legal description, by metes and bounds; section, township, and range, or parts thereof; or book and page number of plat records for platted property, of:

(A) the proposed permit boundary;

(B) the proposed waste processing and/or disposal areas

(5) latitude and longitude of all corners of the permit boundary and the facility entrance;

(6) the location of the site from the nearest town or city;

(7) a description of all processing, storage, and disposal operations and units;

(8) a description of the anticipated waste streams and amount received per day;

(9) data, plans, and specifications for the following:

(A) a demonstration the proposed facility meets the location restrictions of Subchapter 5 of this Chapter;

(B) an operational plan describing how compliance with the operational requirements of Subchapter 19 of this Chapter, as applicable to the proposed facility, will be achieved;

(C) a plan describing how compliance with the stormwater management requirements of Subchapter 17 of this Chapter will be achieved;

(D) plans for closure of the facility in accordance with Subchapter 25 of this Chapter; and

(E) establishment of financial assurance in accordance with Subchapter 27 of this Chapter.

(b) **Information not identified.** DEQ may require the applicant to submit additional data, revise design specifications or propose environmental safeguards as necessary to meet DEQ rules for the protection of human health and the environment.

(c) **Permit modification applications.** An applicant requesting a modification to an existing permit shall submit information identified in this Part related to the proposed modification.

**252:515-41-12. Operational requirements**

(a) **Acceptable wastes.** Only roofing material shall be accepted at a roofing material recycling facility.

(b) **Prohibited wastes.** Non-Hazardous Industrial Waste, Hazardous Waste, and all other non-roofing material shall be prohibited.

(c) **Roofing material.** All roofing material recycling facilities shall separate the recyclable material from the material that will not be recycled. The non-recyclable material shall be kept in roll-offs or other containers that will prevent the material from blowing, leaching, or otherwise causing contamination. All non-recyclable material must be properly disposed at an approved disposal facility within thirty(30) days of receipt.

(d) **Recyclable material.** All roofing material that is intended for recycling must be kept in either containers or piles. Roofing material stored on the ground while awaiting processing shall be placed in piles, as follows:

(1) the base shall not exceed 200 feet by 150 feet;

(2) the height of the pile shall not exceed twenty feet; and

(3) stable side slopes must be maintained.

(e) **Fire lane.** An unobstructed fire lane at least 50 feet in width shall be maintained around the perimeter of each recyclable material pile.

(f) **Buffer zone.** A clean buffer zone of at least 50 feet shall be maintained between recyclable material piles and adjacent properties.

(g) **Weighing roofing material.** Each load of roofing material received shall be weighed on scales tested and certified in accordance with the requirements of the Oklahoma Department of Agriculture, Food and Forestry.

(1) Each truck and/or trailer shall be weighed full and empty.

(2) Gross and tare weights shall be imprinted on the same weight ticket.

(3) Stored tare weights shall not be used.

(h) **Daily log.** A daily log shall be maintained for each load of roofing material received. The daily log shall reflect:

(1) date and time;

(2) name and address of the hauler;

(3) weight;

(4) amount of non-recyclable material shipped to a permitted solid waste disposal site; and

(5) name and location of permitted solid waste disposal site receiving the non-recyclable material.

**252:515-41-14. Financial assurance**

(a) **Required.** Roofing material recycling facilities shall establish financial assurance in accordance with the requirements of Subchapter 515-27, parts 1, 3, and 7 of this Chapter. Subparts 515-27-8, part 3, 515-27-32, and part 5 of this Chapter shall not apply to roofing material recycling facilities.

(b) **Amount.** Unless a lesser amount is approved by DEQ, financial assurance will be established based upon the cost for removal and disposal, by a third party not affiliated with the owner/operator, of the maximum amount of roofing material permitted to be stored on site at any time, removal of equipment, temporary buildings, and re-vegetation.

**252:515-41-15. Closure**

(a) **Closure plan.** Roofing material recycling facilities shall submit, with their permit application, a closure plan addressing the following items:

(1) removal and disposal of all roofing material permitted to be stored on site;

(2) removal of equipment and temporary buildings and other improvements not designated as permanent in the permit application; and

(3) grading and re-vegetation of the site.

(b) **Cost estimates.** Cost estimates for closure shall be based upon the cost for removal and disposal, by a third party not affiliated with the owner/operator, of the maximum amount of roofing material permitted to be stored on site at any time, removal of equipment, temporary buildings, and re-vegetation.

(c) **Closure cost estimate procedures.** The following determinations shall be submitted to DEQ for approval:

(1) identification of the task(s) for which bids will be provided;

(2) a statement of work fully describing the actions necessary for completion of the task(s) identified; and

(3) written bids from three independent contractors not affiliated with the owner/operator. The bids shall be dated within 30 days of submittal and be an estimate of the contractor's cost for performing the work identified in the statement of work on behalf of the State of Oklahoma.

**252:515-41-16. Stormwater management**

Roofing material recycling facilities shall comply with the provisions of Subchapter 17 of this Chapter.

*[OAR Docket #13-777; filed 5-16-13]*

## TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 606. OKLAHOMA POLLUTANT DISCHARGE ELIMINATION SYSTEM (OPDES) STANDARDS

*[OAR Docket #13-783]*

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 1. Introduction
252:606-1-4 [AMENDED]

**AUTHORITY:**
Environmental Quality Board, 27A O.S. § 2-2-101; Water Quality Management Advisory Council, 27A O.S.§ 2-2-201; and 27A O.S.§§ 2-6-103, 2-6-203, 2-6-402 and 2-6-501.

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**SUPERSEDED EMERGENCY ACTIONS:**
n/a

**INCORPORATION BY REFERENCE:**
**Incorporated standards:**
Date of CFR provisions incorporated by reference in these rules is changed to"as published on July 1, 2012"
**Incorporating rule:**
252:606-1-4
**Availability:**
The standards are on file at the Department of Environmental Quality, 707 North Robinson, Oklahoma City, Oklahoma, 73102, and are available to the public for examination Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

**ANALYSIS:**
The Department proposes to update its rules concerning the date of the incorporation by reference for federal regulations from July 1, 2011, to July 1, 2012.

**CONTACT PERSON:**
The contact person is Mark Hildebrand. Mark may be contacted at: Mark.Hildebrand@deq.ok.gov (e-mail), (405) 702-8100 (phone) or (405) 702-8101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The DEQ's mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 1. INTRODUCTION

**252:606-1-4. Date of federal regulations incorporated**

When reference is made to 40 CFR it means, unless otherwise specified, the volume of 40 CFR as published on July 1, ~~2011~~ 2012.

*[OAR Docket #13-783; filed 5-16-13]*

# TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 616. INDUSTRIAL WASTEWATER SYSTEMS

*[OAR Docket #13-784]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. Introduction
252:616-1-2 [AMENDED]
Subchapter 3. Permit Procedures
252:616-3-3 [AMENDED]
Subchapter 7. Surface Impoundments Standards
252:616-7-4 [AMENDED]
252:616-7-5 [AMENDED]
Subchapter 9. Tank System Standards
252:616-9-1 [AMENDED]
Subchapter 11. Land Application Standards
252:616-11-5 [AMENDED]
Subchapter 13. Closure Standards
252:616-13-3 [AMENDED]
Appendix C. Table of Rainfall and Evaporation Data [REVOKED]
Appendix C. Table of Rainfall and Evaporation Data [NEW]
**AUTHORITY:**
Environmental Quality Board, 27A O.S. § 2-2-101; Water Quality Management Advisory Council, 27A O.S.§ 2-2-201; and 27A O.S.§§ 2-6-103, 2-6-203, 2-6-402 and 2-6-501.
**DATES:**
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**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATION BY REFERENCE:**
n/a
**ANALYSIS:**
The Department proposes to amend this Chapter to do the following: (1) update the definitions; (2) clarify that the application fees and annual fees for Class III systems apply to applications for coverage under general permits; (3) change the term "flexible membrane liner" to "synthetic liner" throughout the Chapter; (4) eliminate the use of lateral lines for new industrial tank systems; (5) clarify and update the recordkeeping and reporting requirements for land application systems; and (6) update Appendix C with the latest rainfall and evaporation data.
**CONTACT PERSON:**
The contact person is Mark Hildebrand. Mark may be contacted at: Mark.Hildebrand@deq.ok.gov (e-mail), (405) 702-8100 (phone) or (405) 702-8101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The DEQ's mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. INTRODUCTION

### 252:616-1-2. Definitions

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

**"Beneficial use"** means in the context of land application the use of sludge or wastewater through land application for the purpose of soil conditioning, crop vegetative fertilization, or erosion control, or the use of wastewater for dust suppression where fugitive dust control would otherwise be an air quality problem, in a manner which does not pollute or tend to pollute waters of the state of Oklahoma, the environment or pose a risk to human health.

**"Berm"** means a man-made barrier designed to control waste and/or stormwater within a surface impoundment or to retard or contain runoff in a given area.

**"Bypass"** means the intentional or unintentional diversion of waste streams from any portion of a facility.

**"Cathodic protection"** means protecting a metal from electrochemical corrosion or rusting by using it as the cathode of a cell with a sacrificial anode.

**"Cell"** means a part of a surface impoundment system that shares a vertical concrete wall ~~and berm~~ with another part of the surface impoundment area.

**"DEQ"** means the Oklahoma Department of Environmental Quality.

**"Engineer"** means a professional engineer registered in the state of Oklahoma.

**"Flow-through surface impoundment"** means a surface impoundment designed and constructed with an outfall structure which allows the controlled discharge of wastewater out of the impoundment.

**"Freeboard"** means the vertical distance from the surface water or sludge/solids level to the overflow elevation (outfall structure or the lowest part of the surrounding berm) in a surface impoundment.

**"Hydraulic conductivity"** means the coefficient of proportionality that describes the rate at which a fluid can move through a permeable medium. It is a function of both the medium and of the fluid flowing through it; also defined as the quantity of water that will flow through a unit cross-sectional area of porous material per unit of time under a hydraulic gradient of 1.00 (measured at right angles to the direction of flow) at a specified temperature.

**"Industrial wastewater treatment permit"** shall include any permit for construction, operation, treatment, storage or disposal required under this Chapter.

**"Land application"** means the controlled application of treated industrial wastewater or sludge onto the land surface for beneficial use.

**"Liner"** means a barrier which is designed, constructed and installed in a surface impoundment and which has appropriate chemical and physical properties to ensure that such structures control the seepage or release of waste and wastewater from the impoundment.

**"Monitoring well"** means all borings, wells, piezometers, or other means of retrieving a soil, waste, wastewater or vapor sample from the subsurface.

**"Oklahoma Water Quality Standards"** means the rules promulgated by the Oklahoma Water Resources Board and contained in OAC 785:45 which classify waters of the state, designate beneficial uses for which the various waters of the State shall be maintained and protected, and prescribe the water quality standards required to sustain designated uses.

**"OPDES"** means the Oklahoma Pollution Discharge Elimination System Act at 27A O.S.§ 2-6-201 *et seq*.

**"Operator"** means the person responsible for the maintenance and operation of a surface impoundment, or disposal or wastewater treatment system and responsible for keeping records and providing reports to the DEQ.

**"Outfall"** means the point where monitoring shall occur for the purpose of evaluating compliance with rules, permits or orders of the DEQ.

**"Person"** means any individual, company, corporation, government agency, municipality, or any other entity.

**"Permeability"** means the rate at which liquids pass through soil or other materials in a specified direction.

**"Receiving water"** means that portion of any waters of the State into which wastewater is or may be released, leached, or discharged.

**"Sanitary wastewater"** means and includes but is not limited to wastewater from drinking fountains, showers, toilets, lavatories, and kitchens.

**"Surface impoundment"** means a native soil or lined basin either below or above ground level which is designed, maintained and/or operated to store, recycle, treat and/or dispose of industrial wastewater or stormwater, and shall include but is not limited to lagoons, excavations, basins, diked areas, and pits ~~and ponds~~.

**"~~Flexible membrane~~ Synthetic liner"** means a manufactured liner material composed of plastics, resins or other flexible materials, which is designed and manufactured to be used to control the seepage or release of waste through the liner material.

**"Tank system"** means any subsurface disposal system which involves the storage and treatment of wastewater.

**"Total retention surface impoundment"** means a surface impoundment designed and constructed without an outfall structure.

**"U.S.C."** means United States Code.

**"Waste class"** means the following classification of wastewater, including stormwater:

(A) Class I: containing or suspected to contain pollutants for which the toxicity, concentration and volume pose a significant risk of harm to humans, aquatic life, wildlife or the environment, either through high potential to migrate in groundwater or the likelihood, if discharged, to significantly degrade the beneficial uses of the receiving water as designated in the Oklahoma Water Quality Standards. These wastewaters require the most restrictive environmental protection measures.

(B) Class II: containing or suspected to contain pollutants for which the toxicity, concentration and volume pose a moderate risk of harm to humans, aquatic life, wildlife, or the environment, either through the potential to migrate in groundwater or a reasonable possibility, if discharged, to degrade the beneficial uses of the receiving water as designated in the Oklahoma Water Quality Standards.

(C) Class III: containing or suspected to contain pollutants which do not pose a substantial risk of harm to humans, aquatic life, wildlife, or the environment because of a relative immobility in groundwater or a general lack of direct toxicity, and which are not likely, if discharged, to degrade the beneficial uses of the receiving water as designated in the Oklahoma Water Quality Standards.

(D) Class IV: containing only sanitary wastewater from industrial facilities. Class IV wastewaters are not subject to this Chapter, but are governed by OAC 252:641 (under 5,000 gpd) or by OAC 252:656 (5,000 gpd or more).

(E) Class V: industrial wastewater not otherwise classified.

**"Waste containment system"** means storage tanks, containers and other storage reservoirs, transfer lines, pumps, fittings, overfill prevention devices, and any associated anti-corrosion measures and leak prevention or detection systems.

## SUBCHAPTER 3. PERMIT PROCEDURES

**252:616-3-3. Fees**

(a) **Application fees.** Application fees for new industrial wastewater system permits or to renew existing industrial wastewater system permits are non-refundable~~. The application fees~~ and are set forth below:

(1) Class I - $300.00

(2) Class II - $200.00

(3) Class III and authorizations under a general permit - $100.00

(4) Class V - $300.00

(b) **Annual fees.** Permit holders shall submit payment to DEQ for annual fees upon receipt of an invoice from DEQ. Payments for annual fees received by DEQ shall be applied to the twelve-month period following the due date of the initial invoice issued by DEQ, but not past the expiration of the permit. Failure to pay an annual fee may result in suspension or termination of the permit. The annual fees are set forth below.

(1) **Industrial tank systems.** The annual fees for industrial tank systems are as follows:

(A) Class I or II - $970.00

(B) Class III - $330.00

(C) Class V - $440.00

(2) **Industrial surface impoundments.** The annual fees for industrial surface impoundment systems are as follows:

(A) Class I - $1,670.00 per impoundment

(B) Class II - $1,120.00 per impoundment

(C) Class III and authorizations under a general permit- $330.00 per impoundment

(D) Class V - $440.00 per impoundment

(3) **Land application of industrial wastewater or industrial sludge.** The holder of a permit for an industrial tank or impoundment system that allows for the land application of industrial wastewater and/or industrial sludge shall pay an annual fee of $690.00 in addition to the annual fees set forth in (1) and (2) of this subsection.

(d) **Consumer Price Index adjustment.** To assist in meeting rising costs for the industrial wastewater program, the fees set out in (a), and (b) of this Section shall be automatically adjusted on July 1st every year to correspond to the percentage, if any, by which the Consumer Price Index (CPI) for the most recent calendar year exceeds the CPI for the previous calendar year. The Department may round the adjusted fees up to the nearest dollar. The Department may waive collection of an automatic increase in a given year if it determines other revenues, including appropriated state general revenue funds, have increased sufficiently to make the funds generated by the automatic adjustment unnecessary in that year. A waiver does not affect future automatic adjustments.

(1) Any automatic fee adjustment under this subsection may be averted or eliminated, or the adjustment percentage may be modified, by rule promulgated pursuant to the Oklahoma Administrative Procedures Act. The rulemaking process may be initiated in any manner provided by law, including a petition for rulemaking pursuant to 75 O.S.§ 305 and OAC 252:4-5-3 by any person affected by the automatic fee adjustment.

(2) If the United States Department of Labor ceases to publish the CPI or revises the methodology or base years, no further automatic fee adjustments shall occur until a new automatic fee adjustment rule is promulgated pursuant to the Oklahoma Administrative Procedures Act.

(3) For purposes of this subsection, "Consumer Price Index" or "CPI" means the Consumer Price Index - All Urban Consumers (U.S. All Items, Current Series, 1982-1984=100, CUUR0000SA0) published by the United States Department of Labor. The CPI for a calendar year is the figure denoted by the Department of Labor as the "Annual" index figure for that calendar year.

## SUBCHAPTER 7. SURFACE IMPOUNDMENT STANDARDS

### 252:616-7-4. ~~Flexible membrane~~ Synthetic liners

(a) **Suitability.** A liner system constructed using a soil subbase, a specially prepared subgrade, a ~~flexible membrane~~ synthetic liner ~~(FML)~~, and a protective soil cover can be considered a highly protective liner system and may be appropriate for Class I, II, III or V wastewater and may be required for certain wastewater.

(b) **Pre-construction requirements.** Before construction, classify and test all liner material and submit the following with the industrial wastewater treatment permit application:

(1) design specifications with suitable physical properties of the liner material for percent elongation, strength tests (tensile, tear, breaking, shear, and bonded seam), hydrostatic resistance, percent volatile losses, and reactions to water (absorption and extraction);

(2) design specifications with suitable chemical properties of the liner material for chemical resistance to wastewater, ultraviolet light resistance, and protection against biological decay;

(3) show the liner will maintain physical properties under all prolonged and varying conditions expected at the facility, included but not limited to, temperature variation, UV radiation, biological attack, and waste or wastewater composition; and

(4) show the liner will perform as a physical barrier to waste and wastewater seepage into groundwater.

(c) **Construction requirements.** Construct a ~~flexible membrane~~ synthetic liner system by:

(1) protecting the liner membrane from physical damage by a specially prepared bedding material free of rocks, roots, debris, sharp objects, or foreign matter of a size or shape that could damage the liner;

(2) preventing settlement or stability problems of the subgrade under maximum operational conditions. Vent the subgrade with perforated pipe to reduce gas and hydrostatic pressure;

(3) inspecting each roll of liner material in the field before and during placement by a manufacturer-qualified inspector to meet manufacturer specifications against leaks;

(4) installing liners using commonly accepted industry techniques and practices for bedding and subgrade preparation, anchor trenches of 6-inch minimum depth and placement 9 to 12 inches beyond the dike slope break, ~~FML~~ synthetic liner installation and seaming, and field QA/QC inspections and seam testing;

(5) inspecting seams visually and conduct pressure tests, vacuum tests or other non-destructive seam tests to monitor the effectiveness of personnel and equipment;

(6) maintaining side-slope stability. Exterior side slopes shall be a minimum of 2:1 (horizontal to vertical distance). Internal side slopes shall be between 2.5:1 and 4:1. Use the interfacial friction angle between the soil and the liner material to determine the maximum side-slope angle. All side-slope angles shall be less than the interfacial friction angle; and

(7) taking adequate measures to protect the integrity of the liner. On dike slopes, backfill should consist of at least a 3-inch layer of sand or finely textured soil and covered with at least a 3-inch layer of heavier cobble, coarse gravel, or small riprap.

**252:616-7-5. Composite liners**

(a) **Suitability.** A liner system constructed with both a clay liner and a ~~flexible membrane~~ synthetic liner ~~(FML)~~ is the most protective liner system and is appropriate for Class I, II, III or V wastewater and may be required for Class I wastewater.

(b) **Construction requirements.** Construct composite liners according to the compacted clay liner and ~~flexible membrane~~ synthetic liner provisions of this Subchapter. Smooth the surface of the constructed clay liner until uniform to prevent a zone of high permeability under the ~~flexible membrane~~ synthetic liner.

## SUBCHAPTER 9. TANK SYSTEM STANDARDS

**252:616-9-1. Authorized use of tank systems**

The use of tank systems for all wastewater classifications is authorized as follows:

(1) ~~Tank~~ Existing tank systems without subsurface absorption trenches or lateral lines can be used for the treatment of Class I, II, III, and V wastewater.

(2) ~~Tank~~ Existing tank systems with subsurface absorption trenches or lateral lines are subject to the Underground Injection Control permitting process.

(3) To ensure the protection of groundwater in accordance with OAC 785:45-7, new tank systems shall not utilize subsurface absorption trenches or lateral lines for disposal or dispersal of industrial wastewater.

## SUBCHAPTER 11. LAND APPLICATION STANDARDS

**252:616-11-5. Recordkeeping**

(a) **Records.** ~~Submit yearly to the DEQ~~ The permittee shall keep the following land application records on site and available to DEQ upon request:

(1) location, day and hour land application began and ended, and the method of application;

(2) analytical data, volume and source(s) of wastewater or industrial sludge applied;

(3) loading rates;

(4) weather conditions during the application period;

(5) type of crop, grass or vegetation grown on site;

(6) ~~pH of wastewater at beginning of application, or weekly if application exceeds seven consecutive days; and~~

~~(7)~~ monitoring records, including the date, time and exact place of the sampling or measurement, the name of the sampler, when analysis began, the name of the certified laboratory and the analytical results;

(~~8~~7) for industrial sludge generated outside the State of Oklahoma, test results demonstrating the quality of the sludge, including samples of each load of sludge performed by an independent laboratory approved by the DEQ and an agreement that the DEQ may perform random quality assurance sampling at the site of the generation of the industrial sludge;

(~~9~~8) In the case of dust suppression (OAC 252:616-11-6), the following records must be maintained:

(A) location, day and hour land application began and ended, and the method of application;

(B) volume and source(s) of wastewater applied; and

(C) weather conditions during the application period.

(b) **Reporting to DEQ.**

(1) The ~~owner or operator~~ permittee shall submit reports of required effluent and sludge monitoring and land application records by month on a quarterly basis. The quarterly reports will be due on or before the last working day of the month following the close of each quarter (i.e., April, July, October and January). Monitoring information shall be submitted to the DEQ on self-monitoring report (SMR) forms or other forms provided or approved by the DEQ.

(2) The permittee shall submit reports of land application records on a yearly basis. The yearly reports shall be due on or before January 31. Monitoring information shall be submitted to DEQ on self-monitoring report (SMR) forms or other forms provided or approved by DEQ.

(c) **Notice of changes.** An owner or operator shall give advance notice to the DEQ of any change in sludge or wastewater source(s), treatment or characteristics, method(s) of land application, or the addition of any specific land application site not previously approved in his/her permit. Such change may require a major modification of the permit.

## SUBCHAPTER 13. CLOSURE STANDARDS

**252:616-13-3. Closure plan submittal and amendment**

(a) **Closure plan required.** A written closure plan shall be submitted to the DEQ at least 90
days prior to commencing closure, unless a lesser amount of time is granted by the DEQ.

(b) **Closure plan amendment.** Closure activities shall occur as specified in the closure plan. Any amendments to the closure plan shall be submitted, in writing, to the DEQ for review and approval before any closure activity is altered, replaced, or deleted.

(c) **Commencement of closure activities.** Closure activities shall not commence until the closure plan and all amendments thereto have been reviewed and approved by the DEQ.

(d) **Content.** The written closure plan shall include the following information, except as specifically waived by the DEQ in accordance with OAC 252:616-13-1(c):

(1) **General information.** The following general information shall be provided in all closure plans:

(A) purpose of closure indicating the reason why the surface impoundment, tank system or land application site is no longer in use and whether wastewater or sludge will be closed in place (in-place closure) or removed (clean closure);

(B) the DEQ Industrial Wastewater Treatment Permit number for the facility. If the facility has not been permitted, submit a completed application for a DEQ Industrial Wastewater Treatment Permit;

(C) the name, address, and telephone number of all record owner(s) of the land upon which the surface impoundment, tank system or land application site is located;

(D) if the operator is not the sole record owner of the land, surface property interests and all water rights, they must provide a written document from each owner(s) indicating consent to on-site or off-site disposal of the contents of the surface impoundment, tank system, or land application site and any other activities associated with closure;

(E) provide a time schedule indicating the major closure activities, approximate time to complete each activity, and the estimated date of final completion of all closure activities; and

(F) the closure plan shall include certification by a Registered Professional Engineer, except for Class III impoundments closed pursuant to the specifications contained in Appendix E of this Chapter.

(2) **Site assessment.** The following minimum information about the site shall be provided in the closure plan.

(A) **Soil information.** Identify the type of soil(s) by soil series name impacted and include a description of the soil profile and the depth to bedrock. List chemical and physical properties of the soil, and their average values for the site, that predict transport and fate of the wastewater contained in the surface impoundment, tank system, or land application.

(B) **Groundwater information.** Identify major and minor aquifers, recharge areas, depth to ground water for both shallow aquifer and drinking water sources, local and regional direction of flow, and estimated or background water quality.

(C) **Surface water information.** Identify surface water bodies that may be hydrologically connected to the groundwater or are immediately downgradient of the surface impoundment, tank system or land application site. Trace the drainage to the nearest major watercourse on a topographic map.

(D) **Plans and specifications.** Provide plans and specifications of the impoundment(s), or tank system(s) to be closed indicating the dimensions of the surface impoundment(s), or tank system(s), location of inflow and outflow piping, location and thickness of sludge, and depth of wastewater in the impoundment.

(3) **Wastewater characterization.** The following minimum information about the wastewater shall be included in the closure plan. Additional information may be required.

(A) **Inventory of wastewater.** Provide an inventory of the types and concentrations of wastewater discharged to the surface impoundment, or tank system. Indicate the frequency and volume of each wastewater that was or may have been discharged to or otherwise placed in the tank system or impoundment.

(B) **Chemical analysis.** When requested by the DEQ, provide a chemical analysis of representative sample(s) of the sludges, sediments, bottom sediments, liners, or other media.

(4) **Sampling, analysis, and monitoring plans.** Sampling, analysis, and monitoring used
before, during, and after closure shall be proposed to the DEQ in a written plan as follows:

(A) **Sampling and analysis.** Design a sampling and analysis plan that includes all requirements listed in OAC 252:616-5-4.

(B) **Monitoring.** Design a monitoring plan that will adequately monitor groundwater, soil vapor, or other media according to OAC 252:616-5-4.

(C) **Sampling and monitoring locations.** Indicate on a facility map the location of each sampling site, each monitoring site, the direction of groundwater flow, and the wells used to determine groundwater flow direction.

(5) **Treatment, removal, and disposal.** The closure plan shall include the following minimum discussion of treatment, removal, and disposal activities, as well as any additional information requested by the DEQ:

(A) **Treatment.** Describe all methods to be used to treat or reduce any wastewater or sludge from the surface impoundment or tank system (such as chemical or physical treatment, phase separation, waste stabilization, or other method). Provide a written rationale for each treatment method to be used and sufficient evidence of its effectiveness.

(B) **Removal.** Describe all removal activities for all wastewaters, sludges, liner materials, and subsoils (e.g., volume removed, equipment used, dust control, and other activities).

(C) **Backfill.** If the impoundment is to be closed by backfilling with soil, estimate the volume of soil needed. Include discussion of the material to be used as backfill, sampling used to determine the characteristics of the backfill, the method of compaction, and other methods to be used.

(D) **Disposal.** Provide the name and location of any off-site facility to be used to dispose of the tank system, the lateral lines, the piping and fittings, the contents of the tank system or the impoundment, liner materials, or subsoils, and provide the name of the issuing agency, permit number or other information necessary to determine authorization obtained for such disposal.

(6) **In-place closure requirements.** The following additional requirements apply for in-place closure:

(A) If the pollutants cannot be physically removed or must otherwise be closed in-place, the closure plan shall include:

(i) a discussion of remediation alternatives (e.g., clean closure, waste reduction, or chemical,

physical, or biological treatment) and documentation as to effectiveness of each alternative;

(ii) a discussion of containment alternatives, (e.g., waste stabilization, impervious cap, or other system) and documentation as to the effectiveness of the containment measure; and

(iii) a proposal of which remediation or containment alternative(s) will be implemented for each surface impoundment or tank system site.

(B) When impervious caps or covers are proposed to be constructed as a method of closure in connection with a closure plan, the following requirements shall be met:

(i) compacted clay caps used to contain wastes in closed surface impoundments shall have a maximum hydraulic conductivity of 1 x $10^{-7}$ cm/sec and shall be protected by covering with a soil layer. The clay cap shall be designed and constructed according to the requirements of Subchapter 5 relating to clay liners;

(ii) caps containing ~~flexible membrane~~ synthetic liners used to contain wastes in closed impoundments shall be installed according to requirements of Subchapter 5 relating to ~~flexible membrane~~ synthetic liners in addition to manufacturer's and installer's specifications and accepted industry practices and shall be protected by covering with a composite soil and gravel layer; and

(C) address post-closure activities, as required by the DEQ, such as groundwater monitoring, water or land use restrictions, or deed restrictions.

(7) **Clean closure requirement.** The following additional requirements apply for clean closure:

(A) provide an evaluation of the feasibility of clean closure of the surface impoundment, tank system site including a discussion of available technology, extent of contamination, and other factors; and

(B) discuss target clean-up levels of wastewater, the possible risks at those levels, and the methods to be used to determine that clean closure has been achieved.

## APPENDIX C. TABLE OF RAINFALL AND EVAPORATION DATA [REVOKED]

## APPENDIX C. TABLE OF RAINFALL AND EVAPORATION DATA [NEW]

| County | Rainfall * (in inches) | Average Pan Evaporation (in inches) | Average Lake Evaporation (in inches) | County | Rainfall * (in inches) | Average Pan Evaporation (in inches) | Average Lake Evaporation (in inches) |
|---|---|---|---|---|---|---|---|
| Adair | 59.90 | 65 | 47 | LeFlore | 62.01 | 65 | 48 |
| Alfalfa | 38.12 | 90 | 62 | Lincoln | 46.13 | 80 | 57 |
| Atoka | 61.45 | 75 | 53 | Logan | 46.06 | 85 | 60 |
| Beaver | 28.57 | 90 | 62 | Love | 51.56 | 80 | 58 |
| Beckham | 32.86 | 90 | 64 | McClain | 48.08 | 85 | 60 |
| Blaine | 38.17 | 90 | 62 | McCurtain | 67.41 | 65 | 49 |
| Bryan | 55.60 | 75 | 54 | McIntosh | 59.39 | 70 | 52 |
| Caddo | 39.15 | 90 | 63 | Major | 35.22 | 90 | 63 |
| Canadian | 44.44 | 90 | 62 | Marshall | 55.70 | 75 | 55 |
| Carter | 50.87 | 80 | 58 | Mayes | 56.42 | 70 | 49 |
| Cherokee | 61.28 | 70 | 48 | Murray | 55.89 | 80 | 58 |
| Choctaw | 61.42 | 70 | 52 | Muskogee | 56.82 | 80 | 50 |
| Cimarron | 21.70 | 90 | 58 | Noble | 47.27 | 85 | 59 |
| Cleveland | 46.59 | 85 | 60 | Nowata | 50.93 | 70 | 51 |
| Coal | 64.06 | 75 | 55 | Okfuskee | 51.62 | 75 | 55 |
| Comanche | 42.08 | 90 | 64 | Oklahoma | 44.53 | 85 | 60 |
| Cotton | 44.22 | 90 | 64 | Okmulgee | 56.29 | 75 | 53 |
| Craig | 59.59 | 70 | 49 | Osage | 50.81 | 75 | 54 |
| Creek | 52.16 | 75 | 55 | Ottawa | 64.92 | 65 | 47 |
| Custer | 39.05 | 90 | 64 | Pawnee | 46.58 | 80 | 56 |
| Delaware | 62.82 | 65 | 47 | Payne | 44.24 | 80 | 52 |
| Dewey | 33.48 | 90 | 63 | Pittsburg | 54.33 | 75 | 58 |
| Ellis | 29.83 | 90 | 64 | Pontotoc | 49.44 | 75 | 56 |
| Garfield | 43.26 | 90 | 61 | Pottawatomie | 47.71 | 80 | 58 |
| Garvin | 45.02 | 80 | 59 | Pushmataha | 65.61 | 70 | 50 |
| Grady | 44.55 | 90 | 62 | Roger Mills | 35.52 | 90 | 64 |
| Grant | 44.11 | 90 | 60 | Rogers | 54.57 | 70 | 51 |
| Greer | 37.31 | 90 | 64 | Seminole | 52.15 | 75 | 55 |
| Harmon | 36.93 | 90 | 64 | Sequoyah | 55.66 | 65 | 48 |
| Harper | 29.66 | 90 | 62 | Stephens | 44.28 | 85 | 62 |
| Haskell | 61.04 | 70 | 49 | Texas | 24.53 | 90 | 62 |
| Hughes | 53.92 | 75 | 54 | Tillman | 41.14 | 90 | 64 |
| Jackson | 39.39 | 90 | 64 | Tulsa | 49.54 | 75 | 53 |
| Jefferson | 42.08 | 85 | 61 | Wagoner | 52.50 | 70 | 51 |
| Johnston | 61.46 | 75 | 55 | Washington | 49.79 | 70 | 53 |
| Kay | 46.96 | 80 | 58 | Washita | 40.55 | 90 | 64 |
| Kingfisher | 40.77 | 90 | 62 | Woods | 35.42 | 90 | 62 |
| Kiowa | 35.84 | 90 | 64 | Woodward | 31.93 | 90 | 62 |
| Latimer | 73.97 | 70 | 50 | * Rainfall data is the 90th percentile | | | |

Source of data: OGS average rainfall data for 1970 – 2004; evaporation data from 1976 OSDH Design Guidelines

*[OAR Docket #13-784; filed 5-16-13]*

# TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 631. PUBLIC WATER SUPPLY OPERATION

*[OAR Docket #13-785]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. Introduction
252:631-1-3 [AMENDED]
Subchapter 3. Operations
252:631-3-3 [AMENDED]
252:631-3-21 [AMENDED]
**AUTHORITY:**
Environmental Quality Board, 27A O.S. § 2-2-101; Water Quality Management Advisory Council, 27A O.S.§ 2-2-201; and 27A O.S.§§ 2-6-103 and 2-6-306.
**DATES:**
**Comment period:**
December 1, 2012, through December 31, 2012
**Public hearing:**
January 8, 2013 and February 22, 2013
**Adoption:**
February 22, 2013
**Submitted to Governor:**
February 28, 2013
**Submitted to House:**
February 28, 2013
**Submitted to Senate:**
February 28, 2013
**Gubernatorial approval:**
April 8, 2013
**Legislative approval:**
Approved May 10, 2013 by Senate Joint Resolution #35.
**Final adoption:**
May 10, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATION BY REFERENCE:**
**Incorporated standards:**
Date of CFR provisions incorporated by reference in these rules is changed to " as published on July 1, 2012" and the following additional provisions are incorporated by reference:
40 CFR §§ 141.400 - 141.405
40 CFR §§ 141.600 - 141.605
40 CFR §§ 141.620 - 141.629
40 CFR §§ 141.700 - 141.723
**Incorporating rules:**
252:631-1-3
**Availability:**
The standards are on file at the Department of Environmental Quality, 707 North Robinson, Oklahoma City, Oklahoma, 73102, and are available to the public for examination Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.
**ANALYSIS:**
The Department proposes to: (1) update its rules concerning the date of the incorporation by reference of certain federal regulations from July 1, 2011, to July 1, 2012; (2) incorporate by reference the federal regulations relating to the Ground Water Rule, the Long-term 2 Enhanced Surface Water Treatment Rule, and the Stage 2 Disinfectants and Disinfection Byproducts Rule; (3) update the analytical testing methods when using chloramines as a disinfectant; and (4) increase the annual fees for public water supply systems.
**CONTACT PERSON:**
The contact person is Mark Hildebrand. Mark may be contacted at: Mark.Hildebrand@deq.ok.gov (e-mail), (405) 702-8100 (phone) or (405) 702-8101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The DEQ's mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. INTRODUCTION

### 252:631-1-3. Adoption of U.S. EPA regulations by reference

The provisions of Parts 141, "National Primary Drinking Water Regulations," and 143, "National Secondary Drinking Water Regulations," of Title 40 of the Code of Federal Regulations (CFR) as published on July 1, ~~2011~~ 2012, and the requirements contained therein are, unless otherwise specified, adopted and incorporated by reference~~, except for the following:~~

~~(1) 40 CFR §§ 141.400 - 141.405;~~
~~(2) 40 CFR §§ 141.600 - 141.605;~~
~~(3) 40 CFR §§ 141.620 - 141.629; and~~
~~(4) 40 CFR §§ 141.700 - 141.723~~.

## SUBCHAPTER 3. OPERATIONS

### 252:631-3-3. Disinfection requirements

(a) **Mandatory disinfection.** Full-time disinfection is mandatory for:

(1) surface water, groundwater under the direct influence of surface water, and spring water supplies unless an alternative has been approved by the DEQ. Each of these systems shall provide disinfection in accordance with 40 CFR Section 141.72(b) and meet the monitoring requirements contained in 40 CFR Section 141.74(c).

(2) groundwater supplies or purchase water systems whenever their record of bacteriological tests show:

(A) a persistent presence of Total Coliform; or

(B) a verified Fecal Coliform, or E. Coli MCL exceedance;

(3) PWS systems that purchase water from a public water supply under mandatory disinfection, unless the purchase water system verifies chlorine residuals that are in compliance with (c) or, if chloramines are used, (d) of this Section; and

(4) any new well in a system where the initial bacteriological tests of the well do not show a safe record with the DEQ for two (2) consecutive days after completion and testing of the well.

~~(b) **Level of disinfection.** The disinfection method shall be sufficient to ensure that, at the point of entry into the distribution system, the total treatment processes of the system achieve:~~

~~(1) at least 99.9 percent (3-log) inactivation and/or removal of *Giardia lamblia* cysts; and~~

~~(2) at least 99.99 percent (4-log) inactivation and/or removal of viruses;~~

(~~c~~b) **Modification of disinfection methods.** When any change in the disinfection process is contemplated, contact the DEQ. Submittal of an application, including plans, specifications, engineering reports, disinfection profile and disinfection benchmark justifying such a change may be required in order to obtain approval from the DEQ.

(~~d~~c) **Chlorine.** The minimum free chlorine residuals shall be as follows:

(1) **Most distant points.** The minimum free chlorine residual at the most distant points in a water distribution system must be 0.2 mg/l.

(2) **Point of entry.** The minimum free chlorine residual at the POE shall be at 1.0 mg/l. For supplies that document they meet or exceed the inactivation requirements in OAC 252:631-3-3(a)(1), the minimum free chlorine residual at the POE shall be 0.2 mg/l.

(~~e~~d) **Chloramines.**

(1) **Prior public notice.** Systems must notify all users of kidney dialysis machines at least one month before introducing chloramines into the distribution system or starting chloramination.

(2) **Chloramines engineering study.** Before changing to chloramines as the residual disinfectant in the distribution system, the system must conduct and submit to the DEQ for approval an engineering study and weekly analyses for at least six (6) weeks prior to and quarterly for one year following such a change of disinfectant. The engineering study and analysis must address the following:

(A) Select at least four (4) sample points for each treatment plant used by the system. At least twenty-five percent (25%) of the sample points must be at locations within the distribution system reflecting the maximum residence time of water in the system; and

(B) Collect samples from the selected points weekly for six (6) weeks and perform the following analyses using the methods approved in 40 CFR 141.74(a)(1) before modification of treatment is initiated:

(i) Total coliform;

(ii) Fecal coliform; and

(iii) ~~Enterococcus subgroup of the fecal streptococcus group of bacteria; and~~

~~(iv)~~ ~~Standard plate counts at 35E~~Heterotrophic Plate Count

(3) **Continuing testing.** After modification of the treatment process, perform the bacteriological tests for samples collected at each of the selected points at quarterly intervals for one year, and then annually, when samples are collected for total trihalomethane determination. Submit the results to the DEQ.

(4) **Primary Disinfection.** A disinfectant must be added to provide the required log inactivation of *Giardia Lamblia* cysts before ammonia is added.

(5) **Total chlorine.** The minimum total chlorine residual at the most distant points in a water distribution system must be 1.0 mg/l and at least 2.0 mg/l at the POE. Higher residuals may be required depending on pH, temperature and other characteristics of the water.

(~~f~~e) **Other disinfectants.** Iodine or bromine compounds must not be used as a disinfectant. Ozone or ultraviolet light may be used for in-plant treatment or disinfection provided an approved residual disinfectant is added prior to distribution and maintained according to this chapter. Chlorine dioxide may be used as long as the requirements in this chapter are met.

(~~g~~f) **Process control tests for disinfectants.** Control tests must be performed by all systems that disinfect in accordance with procedures approved by the DEQ. Sampling points must be changed regularly so that the system is sampled completely at least once each week.

(1) **Chlorine.** Systems that use chlorine must test for free chlorine and total chlorine residual twice a day in the distribution system.

(2) **Chloramines.**

(A) Systems that use chloramines must test for total chlorine residual twice a day in the distribution system.

(B) Systems that use chloramines must submit yearly ~~standard plate count~~ Heterotrophic Plate Count ~~and enterococcus samples~~ from the distribution system in order to document that no microbiological regrowth is occurring in the distribution system.

(C) The minimum total chlorine residual at the most distant points in a water distribution system must be 1.0 mg/l.

(D) Total chlorine residuals must be at least 2.0 mg/l at the POE. Higher residuals may be required depending on pH, temperature and other characteristics of the water.

(3) **Other disinfectants.**

(A) Systems that use chlorine dioxide, ozone or ultraviolet light must maintain a free chlorine residual, or total chlorine residual, where chloramines are used, in accordance with OAC 252:631-3-3(a) ~~and (b)~~.

(B) Systems that use ozone or chlorine dioxide must perform process control tests in accordance with 40 CFR Section 141.132.

**252:631-3-21. Public water supply annual service fees**

(a) Each PWS system shall be charged an annual fee (see 27A O.S.§ 2-6-306).

(b) ~~Beginning July 1, 2008, the~~ The PWS annual fee shall be calculated using the actual costs of services as follows:

(1) Laboratory analysis fees, for parameters analyzed by the State Environmental Laboratory, shall be charged as specified in OAC 252:305, "Laboratory Services";

(2) Inspection service costs equal ~~$36.00~~ $50.00 for purchase systems, ~~$72.00~~ $100.00 for ground systems or ~~$143.00~~ $200.00 for surface systems and groundwater under the direct influence of surface water systems; and

(3) Federal program requirement costs for tracking, reporting, and enforcement and technical assistance costs (applicable to community systems and non-transient non-community systems) equal ~~$266.00~~ $370.00 for purchase systems, ~~$1,167.00~~ $1,600.00 for ground systems or

~~$4,980.00~~ $6,800.00 for surface systems and groundwater under the direct influence of surface water systems.

(c) Each system shall be charged the actual cost for regulatory services as calculated according to OAC 252:631-3-21(b), except that:

(1) no system shall pay less than a minimum annual fee of $50 for purchase water systems, $75 for ground water systems and $150 for surface water system or less than four cents ($0.04) per service connection per month, whichever is greater, and

(2) no system shall pay an annual fee increase of more than thirty cents ($0.30) per service connection per month.

(d) The minimum annual fees listed in OAC 252:631-3-21(c) do not apply to state, federal, tribal, and non-transient non-community systems. These systems shall pay the actual costs of services.

(e) Each system will be notified by mail of the fee due from that system by August 1 of each year. The DEQ shall mail such notice to the most recent name and address provided to the DEQ by the PWS system, however, failure to receive such notice by the system shall not operate to waive any fees due to the DEQ.

(f) To assist in meeting rising costs to the Department of the public water supply program associated with implementation and enforcement of the federal primary drinking water standards, the fees set out in paragraph (b) above shall be automatically adjusted on July 1st every year to correspond to the percentage, if any, by which the Consumer Price Index (CPI) for the most recent calendar year exceeds the CPI for the previous calendar year. The Department may round the adjusted fees up to the nearest dollar. The Department may waive collection of an automatic increase in a given year if it determines other revenues, including appropriated state general revenue funds, have increased sufficiently to make the funds generated by the automatic adjustment unnecessary in that year. A waiver does not affect future automatic adjustments.

(1) Any automatic fee adjustment under this subsection may be averted or eliminated, or the adjustment percentage may be modified, by rule promulgated pursuant to the Oklahoma Administrative Procedures Act. The rulemaking process may be initiated in any manner provided by law, including a petition for rulemaking pursuant to 75 O.S.§ 305 and OAC 252:4-5-3 by any person affected by the automatic fee adjustment.

(2) If the United States Department of Labor ceases to publish the CPI or revises the methodology or base years, no further automatic fee adjustments shall occur until a new automatic fee adjustment rule is promulgated pursuant to the Oklahoma Administrative Procedures Act.

(3) For purposes of this subsection, "Consumer Price Index" or "CPI" means the Consumer Price Index - All Urban Consumers (U.S. All Items, Current Series, 1982-1984=100, CUUR0000SA0) published by the United States Department of Labor. The CPI for a calendar year is the figure denoted by the Department of Labor as the "Annual" index figure for that calendar year.

*[OAR Docket #13-785; filed 5-16-13]*

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# TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 690. WATER QUALITY STANDARDS IMPLEMENTATION

*[OAR Docket #13-786]*

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 1. Introduction
252:690-1-4 [AMENDED]
Subchapter 3. Point Source Discharges
252:690-3-5 [AMENDED]
252:690-3-8 [AMENDED]
252:690-3-12 [AMENDED]
252:690-3-19 [AMENDED]
252:690-3-32 [AMENDED]
252:690-3-86 [AMENDED]
252:690-3-89 [AMENDED]
252:690-3-91 [AMENDED]
APPENDIX C. Methodology and Equations for Characterizing Effluent and Background Concentrations in Determination of Reasonable Potential to Exceed Numerical Criteria [REVOKED]
APPENDIX C. Methodology and Equations for Characterizing Effluent and Background Concentrations in Determination of Reasonable Potential to Exceed Numerical Criteria [NEW]
APPENDIX I. Performance-Based Effluent Monitoring Frequency Reductions [REVOKED]
APPENDIX I. Performance-Based Effluent Monitoring Frequency Reductions and Increases [NEW]
APPENDIX J. Background Monitoring [REVOKED]
APPENDIX J. Background Monitoring [NEW]

**AUTHORITY:**
Environmental Quality Board, 27A O.S. § 2-2-101; Water Quality Management Advisory Council, 27A O.S.§ 2-2-201; and Water Quality, 27A O.S.§ 2-6-101 *et seq.*

**DATES:**
**Comment period:**
December 1, 2012, through December 31, 2012
**Public hearing:**
January 8, 2013 and February 22, 2013
**Adoption:**
February 22, 2013
**Submitted to Governor:**
February 28, 2013
**Submitted to House:**
February 28, 2013
**Submitted to Senate:**
February 28, 2013
**Gubernatorial approval:**
April 8, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on April 30, 2013
**Final adoption:**
April 30, 2013
**Effective:**
July 1, 2013

**SUPERSEDED EMERGENCY ACTIONS:**
n/a

**INCORPORATION BY REFERENCE:**
**Incorporated standards:**
Date of CFR provisions incorporated by reference in these rules is changed to"as published on July 1, 2012"
**Incorporating rule:**
252:690-1-4
**Availability:**
The standards are on file at the Department of Environmental Quality, 707 North Robinson, Oklahoma City, Oklahoma, 73102, and are available to the public for examination Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

**ANALYSIS:**

The Department proposes to: (1) update the publication date of the federal rules incorporated by reference from July 1, 2010, to July 1, 2012; (2) clarify when and how to use geometric and arithmetic means for determining "reasonable potential" for pollutants; (3) update formulas used to determine when background monitoring is required; clarify testing requirements for facilities with WET limits during a TIE or TRE; (4) update bacteriological indicators to reflect water quality standards for E. coli and Enterococci; (5) require permittees to monitor for bacteria once a week if the receiving stream has a Secondary Body Contact Recreation beneficial use and is impaired for bacteria; (6) eliminate monitoring frequency reductions for bacteriological testing to be consistent with Oklahoma Water Resources Board rules; and (7) make other minor clarifications.

**CONTACT PERSON:**

The contact person is Mark Hildebrand. Mark may be contacted at: Mark.Hildebrand@deq.ok.gov (e-mail), (405) 702-8100 (phone) or (405) 702-8101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The DEQ's mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. INTRODUCTION

### 252:690-1-4. Incorporation of EPA regulations by reference

The following federal regulations at 40 CFR, as published on July 1, ~~2010~~ 2012 are incorporated by reference and applicable to this Chapter:

(1) **OAC 252:205 (Hazardous Waste Management).** 124.31, 124.32, & 124.33, substituting DEQ for EPA, and deleting the following sentence from each section: For the purposes of this section only, "Hazardous waste management units over which EPA has permit issuance authority" refers to hazardous waste management units for which the State where the units are located has not been authorized to issue RCRA permits pursuant to 40 CFR part 271.

(A) **Part 260.** Hazardous Waste Management System: General, except 260.21.

(i) In 260.20, "Federal Register" is synonymous with "The Oklahoma Register."

(ii) In 260.20(e), strike the words "or a denial."

(iii) In 260.22, references to the lists in Subpart D of Part 261 and the reference to § 261.3(a)(2)(ii) or C shall mean the lists in Subpart D of Part 261 and § 261.3(a)(2)(ii) or C as adopted by reference and applicable in Oklahoma.

(iv) In the 260.10 definitions of "new tank system" and "existing tank system", the reference to "July 14, 1986" for commencement of tank installation applies only to tank regulations promulgated pursuant to the federal Hazardous and Solid Waste Amendment ("HSWA") requirements. The following categories outline HSWA requirements:

(I) interim status and permitting requirements applicable to tank systems owned and operated by small quantity generators [3001(d)];

(II) leak detection requirements for all new underground tank systems [3004(o)(4)]; and

(III) permitting standards for underground tanks that cannot be entered for inspection [3004(w)]. For tank regulations promulgated pursuant to statutory authority other than HSWA, the date relative to the commencement of installation is November 2, 1987.

(B) **Part 261.** Identification and Listing of Hazardous Waste except 261.4(b)(18) which pertains to Utah only, thus should be excluded.

(i) In 261.4(e)(3)(iii) delete "in the Region where the sample is collected".

(ii) In 261.5(f)(3)(iv), and (v), and in 261.5(g)(3)(iv), and (v) add "other than Oklahoma" after the word "State".

(iii) In 261.31(a), the listing for F019, add at the end: "Zinc phosphate sludges meeting exemption conditions remain subject to regulation as hazardous waste if the waste exhibits a hazardous waste characteristic."

(C) **Part 262.** Standards Applicable to Generators of Hazardous Waste except Subpart E and Subpart H. In 262.42(a)(2) and 262.42(b) delete "for the Region in which the generator is located".

(D) **Part 263.** Standards Applicable to Transporters of Hazardous Waste.

(E) **Part 264.** Standards for Owners and Operators of Hazardous Waste Treatment Storage, and Disposal Facilities. The following sections and subsections are not adopted by reference: 264.1(f), 264.1(g)(12), 264.149, 264.150, 264.301(l), 264.1030(d), 264.1050(g), 264.1080(e), 264.1080(f), and 264.1080(g).

(i) In 264.191(a), the compliance date of January 12, 1988 applies only for HSWA tanks. For non-HSWA tanks the compliance date is November 2, 1988.

(ii) In 264.191(c), the reference to July 14, 1986 applies only to HSWA tanks.For non-HSWA tanks the applicable date is November 2, 1987.

(iii) In 264.193, the Federal effective dates apply to HSWA tanks only. For non-HSWA tanks January 12, 1987 is replaced with November 2, 1987.

(iv) In 264.570(a) the dates December 6, 1990 and December 24, 1992 apply only to drip pads where F032 waste is handled. The dates June 22, 1992 and August 15, 1994 respectively, replace the dates December 6, 1990 and December 24, 1992 for drip pads where F034 or F035 wastes are handled.

(F) **Part 265.** Interim Status Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities except

265.1(c)(4), 265.1(g)(12), 265.149, 265.150, 265.1030(c), 265.1050(f), 265.1080(e), 265.1080(f), and 265.1080(g).

(i) In 265.191(a), the compliance date of January 12, 1988 applies only for HSWA tanks. For non-HSWA tanks the compliance date is November 2, 1988.

(ii) In 265.191(c), the reference to July 14, 1986 applies only to HSWA tanks. For non-HSWA tanks the applicable date is November 2, 1987.

(iii) In 265.193, the Federal effective dates apply to HSWA tanks only. For non-HSWA tanks January 12, 1987 is replaced with November 2, 1987.

(iv) In 265.440(a) the dates December 6, 1990 and December 24, 1992 apply only to drip pads where F032 waste is handled. The dates June 22, 1992 and August 15, 1994 respectively, replace the dates December 6, 1990 and December 24, 1992 for drip pads where F034 or F035 wastes are handled.

(G) **Part 266.** Standards for the Management of Specific Hazardous Wastes and Specific Types of Hazardous Waste Management Facilities. Due to an early incorporation by reference, for purposes of Part 266 only, HSWA and non-HSWA dates are the same. In 266.325, the reference to 10 CFR 1.5 is changed to 10 CFR 71.5.

(H) **Part 267.** Standards for Owners and Operators of Hazardous Waste Facilities Operating Under a Standardized Permit. This permit option shall only be available to:

(i) those persons who generate hazardous waste on-site through, or as a result of, industrial production processes;

(ii) wholly owned subsidiaries, owners, or sister companies of those persons specified in paragraph (1); and

(iii) agencies, departments, or units of the federal government or the State of Oklahoma.

(I) **Part 268.** Land Disposal Restrictions, except 268.5, 268.6, 268.13, 268.42(b) and 268.44(a) through (g). In 268.7 (a)(9)(iii) exclude D009 from the list of alternative treatment standards for lab packs.

(J) **Part 270.** The Hazardous Waste Permit Program, except 270.1(c)(2)(ix), and 270.14(b)(18).

(K) **Part 273.** Standards for Universal Waste Management.

(L) **Part 279.** Standards for the Management of Used Oil, except that 279.82 is revised to read in its entirety, "The use of used oil as a dust suppressant is prohibited."

(2) **OAC 252:606 (Discharge Standards).**

(A) Part 116 (Hazardous Substances List)

(B) Part 117 (Reportable Quantities for Hazardous Substances)

(C) The following from PART 122 (NPDES PERMIT REGULATIONS):

(i) 122.2 - (definitions)

(ii) 122.24 - (concentrated aquatic animal production facilities)

(iii) 122.25 - (aquaculture projects)

(iv) 122.26 - (stormwater discharges)

(v) 122.27 - (silviculture)

(vi) 122.28(a) and (b) - (general permits)

(vii) 122.29 - (new sources and new dischargers)

(viii) 122.32 - As an operator of a small MS4, am I regulated under the NPDES storm water program?

(ix) 122.34 - As an operator of a regulated small MS4, what will my NPDES MS4 storm water permit require?

(x) 122.35 - As an operator of a regulated small MS4, may I share the
responsibility to implement the minimum control measures with other entities?

(xi) 122.41 - (permit conditions)

(xii) 122.42 - (conditions for specified categories of permits)

(xiii) 122.43 - (establishing permit conditions)

(xiv) 122.44 - (establishing permit limitations, standards and other conditions)

(xv) 122.45 - (calculating permit conditions)

(xvi) 122.46 - (permit duration)

(xvii) 122.47(a) - (schedules of compliance)

(xviii) 122.48 - (monitoring requirements)

(xix) 122.50 - (disposal into wells)

(xx) 122.61 - (permit transfer)

(xxi) 122.62 - (permit modification)

(xxii) 122.63 - (minor modifications of permits)

(xxiii) 122.64 - (permit termination)

(xxiv) Appendices A through J

(D) The following from PART 125 (criteria and standards for NPDES):

(i) Subpart A (technology-based treatment),

(ii) Subpart B (criteria for aquaculture projects),

(iii) Subpart D (fundamentally different factors),

(iv) Subpart H (alternative effluent limitations),

(v) Subpart I (new cooling water intakes),

(vi) Subpart J (existing cooling water intakes), and

(vii) Subpart L (disposal of sewage sludge under CWA 405)

(E) Part 129 (Toxic Pollutant Effluent Standards)

(F) Part 136 (testing and laboratory)

(G) Sections 401-471 (Effluent Guidelines 7 and Standards)

(H) Section 110.6 (notice of oil discharge)

(I) Part 302 (CERCLA exemption from NPDES permits)

(J) The following Sections from Part 503, Subpart A (General Provisions):
(i) 503.1 (Purpose and applicability)
(ii) 503.2 (Compliance period)
(iii) 503.3 (Permits and direct enforceability)
(iv) 503.4 (Relationship to other regulations)
(v) 503.5 (Additional or more stringent requirements)
(vi) 503.6(a)-(e),(g)-(j) (Exclusions)
(vii) 503.7 (Requirement for a person who prepares biosolids)
(viii) 503.8 (Sampling and analysis)
(ix) 503.9 (General definitions)
(K) The following Sections from Part 503, Subpart B (Land Application):
(i) 503.10(a),(b)(1)&(2),(e),(f),(g) (Applicability)
(ii) 503.11 (Special definitions)
(iii) 503.12 (General requirements)
(iv) 503.13 (Pollutant limits)
(v) 503.14 (Management practices)
(vi) 503.15 (Operational standards - pathogens and vector attraction reduction)
(vii) 503.16(a) (Frequency of monitoring)
(viii) 503.17(a) (Recordkeeping)
(ix) 503.18 (Reporting)
(L) The following Sections from Part 503, Subpart D (Pathogens and Vector Attraction Reduction):
(i) 503.30 (Scope)
(ii) 503.31 (Special definitions)
(iii) 503.32(a), (b) (Pathogens)
(iv) 503.33(a), (b)(1)-(11) (Vector attraction reduction)
(M) The following Sections from Part 503 Subpart E (Incineration)
(i) 503.40 (Applicability)
(ii) 503.41 (Special definitions)
(iii) 503.42 (General requirements)
(iv) 503.43 (Pollutant (Metal) limits)
(v) 503.44 (Operational standard - total hydrocarbons)
(vi) 503.45 (Management practices)
(vii) 503.46 (Frequency of monitoring)
(viii) 503.47 (Recordkeeping)
(ix) 503.48 (Reporting)
(N) The following Appendices from Part 503:
(i) Appendix A (Procedure to determine the annual whole sludge application rate for a sludge)
(ii) Appendix B (Pathogen treatment processes)
(O) Provisions of 40 CFR relating to CAFOs are excluded because they are beyond the jurisdiction of this Chapter.

(3) **OAC 252:611 (General Water Quality)** Part 130 (Water Quality Planning and Management)

(4) **OAC 252:652 (Underground Injection Control).** The following apply in their entirety as they apply to the underground injection control program:
(A) Part 144 (Underground Injection Control Program)
(B) Part 145 (State UIC Program Requirements)
(C) Part 146 (Underground Injection Control Program: Criteria and Standards)
(D) Part 147 (State Underground Injection Control Programs)
(E) Part 148 (Hazardous Waste Injection Restrictions)

(5) In all cases where these rules conflict with or are less stringent than federal regulations, the federal regulations apply.

## SUBCHAPTER 3. POINT SOURCE DISCHARGES

### 252:690-3-5. $C_{E(mean)}$ for effluent characterization for determining reasonable potential for parameters other than temperature

Geometric means ~~are preferred and will~~ shall be ~~calculated~~ used~~if sufficient individual data points are available~~ when at least ten (10) individual data points are available. A geometric mean ~~must be~~ shall be calculated ~~from~~ using individual measurement values. ~~The DEQ will not calculate a geometric mean~~ Geometric means may not be calculated ~~from~~ using DMR monthly averages~~. Where a~~, unless the DMR monthly average is the result of only two measurements~~, the individual data point values may be determined~~. ~~If the geometric mean cannot be determined~~ If fewer than ten (10) data points are available, the arithmetic mean ~~will~~ shall be used. Arithmetic and geometric means ~~are~~ shall be calculated according to Equations C-1 and C-2 in Appendix C, respectively.

### 252:690-3-8. $C_{95}$ for determining reasonable potential for parameters other than temperature

(a) **Existing discharges.** If ~~less~~ fewer than ~~10~~ ten (10) effluent data points are available, the $C_{95}$ effluent concentration is determined by multiplying $C_{E(mean)}$ by 2.135 where $C_{E(mean)}$ is the arithmetic mean. If only a single effluent data point is available, it is $C_{E(mean)}$ for the purpose of determining $C_{95}$. Where ~~10~~ ten (10) or more effluent data points are available, the $C_{95}$ concentration is calculated directly from the effluent data set according to Equation C-8.

(b) **New discharges.** For new discharges, $C_{95}$ is estimated by multiplying the expected average effluent quality, $C_{E(mean)}$, by 2.135. Where new industrial facility discharges include cooling tower blowdown from a recirculating cooling water system, permit applicants must submit the results of at least three (3) water samples collected from the cooling water source. The samples must be collected on different days no more than one (1) year prior to submission of the application. The applicant must estimate the $C_{95}$ concentration of the blowdown discharge using the source water monitoring data, based on the projected number of recirculation cycles.

**252:690-3-12. Background monitoring and frequency**

~~Where~~ When effluent limits ~~are not~~ have not been established ~~for a substance~~ and a complete background data set ~~meeting~~ that meets the requirements of OAC 252:690-3-11 is not available, ~~the BT/C ratio~~, the appropriate BT/C equation in Appendix J ~~is used~~ shall be used to determine whether background monitoring is required. ~~Where the BT/C ratio is less than 1.0, $C_{95}$ exceeds the associated water quality criterion, indicating that reasonable potential could be exhibited were the background level high enough.~~ If the BT/C ratio is less than or equal to the $(BT/C)_{max}$ value ~~obtained using Equation J-1, J-2 or J-3, 2 as appropriate~~ using the appropriate equation in Appendix J, background monitoring is required and the monitoring frequency must be sufficient to provide at least ~~10~~ ten (10) data points over a period of one year. The collected background data shall be used in conjunction with the effluent data to determine if there is reasonable potential for the effluent to violate water quality standards.

**252:690-3-19. TREs, TIEs and WET limits**

(a) **TRE and TIE.** A TRE is required ~~where~~ when persistent toxicity is demonstrated. ~~DEQ may require a TRE or TIE where~~ When intermittent toxicity is demonstrated, DEQ may require a TRE/TIE.

(b) **WET limits.** DEQ ~~will~~ shall incorporate a WET limit into a permit for the species affected by whole effluent toxicity upon the completion of a ~~TRE~~ TRE /TIE, unless DEQ determines that chemical-specific effluent limits or toxicity-specific management practices in accordance with OAC 252:690-3-27 are sufficient to comply with the narrative toxicity criterion and protect the designated use. DEQ may also incorporate a WET limit or chemical-specific effluent limits into a permit ~~where~~ when reasonable potential is established ~~by the presence in a discharge of a known toxicant in toxic amounts~~.

(c) **Effective date of WET limit.** The effective date of a WET limit or a chemical-specific limit may be deferred up to three (3) years from the date of completion of the ~~TRE~~ TRE /TIE or the effective date of a permit, as applicable. The effective date of toxicity-specific management practices may be deferred up to one (1) year from the date of completion of the ~~TRE~~ TRE /TIE or the effective date of a permit, as applicable.

**252:690-3-32. Test failure notification and retesting**

Permittees shall notify DEQ by telephone within ~~24~~ twenty-four (24) hours and in writing within five (5) days of becoming aware of a WET test failure and shall perform WET tests/retests on the affected test species. WET tests/retests are required as follows:

(1) **WET limits.** If a permit contains a WET limit, monthly WET tests of the same type as the failed test are required ~~until~~.

(A) If the permittee achieves three (3) consecutive passing tests, ~~at which time~~ the permittee ~~returns~~ may return to ~~the~~ its routine WET testing frequency.

(B) If three (3) consecutive passing tests cannot be achieved in six (6) months, DEQ may require further action, including the possibility of a TIE or a TRE.

(C) If a TIE or a TRE is required or the permittee is in the process of implementing toxicity reduction measures that have resulted from a completed TRE related to the type of failure in question, the permittee may return to its routine WET testing frequency.

(2) **Biomonitoring.** If a permit does not contain a WET limit, two (2) monthly WET retests of the same type as the failed test are required during the ~~two-month~~ two-month period following the month in which the test failure is experienced.

(A) Retests are not required if the permittee is:

(i) actively engaged in conducting a TRE, or

(ii) ~~is~~ in the process of implementing toxicity reduction measures ~~which~~ that:

(I) have resulted from a completed TRE related to the type of failure in question, and

(II) ~~which~~ are reflected in a DEQ-issued compliance schedule.

(B) It is the responsibility of the permittee to request ~~such~~ an exemption from retesting and provide a basis for the request within thirty (30) days of the completion of the failed test.

(C) Retests ~~shall not~~ cannot be substituted for regularly scheduled WET tests.

**252:690-3-86. Implementation of bacteriological criteria to protect the Primary Body Contact Recreation (PBCR) and the Secondary Body Contact Recreation (SBCR) beneficial use**

(a) **PBCR waterbodies - May 1 through September 30.** ~~The~~ When the use of a bacteriological indicator is determined to be necessary, the following ~~PBCR beneficial use~~ bacteriological limitations ~~and monitoring requirements apply~~ shall apply ~~during the period~~ from May 1 through September 30 to protect the PBCR beneficial use: ~~. The fecal coliform MAL of 200 CFU/100ml, expressed as a geometric mean, and the DML of 400 CFU/100ml apply to permittees that discharge fecal coliform. DEQ may use other bacteriological indicators as listed in OAC 785:45 on a case-by-case basis in order to protect the PBCR beneficial use. While a WLA may use other bacteriologicial indicators, compliance with one of the indicators will meet the requirements of this regulation. This does not apply to discharging lagoons in compliance with OAC 252:656-11-2(b) unless Water Quality Standards are violated.~~

(1) **Fecal coliform.** When fecal coliform is the bacteriological indicator:

(A) The monthly geometric mean shall not exceed 200 CFU/100 ml.

(B) The daily maximum for all waterbodies shall not exceed 400 CFU/100 ml.

(2) **Escherichia coli (E. coli).** When E. coli is the bacteriological indicator:

(A) The monthly geometric mean shall not exceed 126 CFU/100 ml.

(B) The daily maximum for lakes shall not exceed 235 CFU/100 ml.

(C) The daily maximum for all waterbodies other than lakes shall not exceed 406 CFU/100 ml.

(3) **Enterococci.** When enterococci is the bacteriological indicator:

(A) The monthly geometric mean shall not exceed 33 CFU/100 ml.

(B) The daily maximum for lakes shall not exceed 61 CFU/100 ml.

(C) The daily maximum for all waterbodies other than lakes shall not exceed 108 CFU/100 ml.

(b) **PBCR waterbodies - October 1 through April 30.** When the use of a bacteriological indicator is determined to be necessary, ~~From October 1 through April 30,~~ the SBCR bacteriological ~~limitation and monitoring requirements, stated~~ limitations listed in ~~OAC 252:690-3-86(b)~~ (c) of this Section~~, are applicable when implementing the PBCR beneficial use~~ shall apply from October 1 through April 30 to protect the PBCR beneficial use when the receiving stream is on the 303(d) list for bacteria.

(~~b~~c) **SBCR waterbodies.** One of the following ~~SBCR beneficial use~~ bacteriological limitations and monitoring requirements ~~apply~~ shall be used year round ~~to~~ for permittees that discharge fecal coliform to waterbodies on the 303(d) list for bacteria: ~~. The fecal coliform MAL of 1000 CFU/100ml, expressed as a geometric mean, and the DML of 2000 CFU/100ml apply to permittees that discharge fecal coliform to waterbodies on the 303(d) list for bacteria.~~

(1) **Fecal coliform.** When fecal coliform is the bacteriological indicator:

(A) The monthly geometric mean shall not exceed 1000 CFU/100 ml.

(B) The daily maximum for all waterbodies shall not exceed 2000 CFU/100 ml.

(2) **Escherichia coli (E. coli).** When E. coli is the bacteriological indicator:

(A) The monthly geometric mean shall not exceed 630 CFU/100 ml.

(B) The daily maximum for lakes shall not exceed 1175 CFU/100 ml.

(C) The daily maximum for all waterbodies other than lakes shall not exceed 2030 CFU/100 ml.

(3) **Enterococci.** When enterococci is the bacteriological indicator:

(A) The monthly geometric mean shall not exceed 165 CFU/100 ml.

(B) The daily maximum for lakes shall not exceed 305 CFU/100 ml.

(C) The daily maximum for all waterbodies other than lakes shall not exceed 540 CFU/100 ml.

~~DEQ may use other bacteriological indicators as listed in OAC 785:45 on a case-by-case basis in order to protect the SBCR beneficial use.~~

(d) **Indicators used in WLA.** ~~While a WLA may use other bacteriologicial indicators, compliance with one of the indicators will meet the requirements of this regulation.~~ Regardless of which bacteriological indicator was used in a permittee's WLA, the permit may contain any one of the three bacteriologic indicators listed above.

(e) **Exception.** This Section does not apply to discharging lagoons that were permitted and are being operated in compliance with OAC 252:656-11-2(b) ~~unless Water Quality Standards are violated~~.

**252:690-3-89. Effluent monitoring frequency ~~where~~ when permit limitations are required**

(a) ~~DEQ may increase monitoring frequency for the parameters listed below for a period not to exceed one year during the initial permit cycle where a permit limit has been established that is required to be monitored, for the purpose of establishing the pattern and extent of variation for a given pollutant.~~ When monitoring is required in a permit, ~~The~~ the following are the minimum monitoring frequencies for parameters during the initial permit cycle ~~where a permit limit has been established that requires monitoring are~~:

(1) ~~one/week~~ once a week for temperature limits.

(2) ~~two/month~~ twice a month for aquatic toxicity criterion-based limits, human health and raw water criterion-based limits, and agriculture criterion-based limits.

(3) for bacteriological limitations:

(A) ~~two/week~~ twice a week during May 1 through September 30 to protect the PBCR beneficial use,

(B) once a week to protect the SBCR beneficial use, if the receiving stream is impaired for bacteria, and

(C) ~~one/week~~ once a week ~~year round~~ for total coliform limits, unless ~~fecal coliform~~ bacteriological limitations for PBCR are also established in the permit, in which case the minimum total coliform monitoring frequency will be ~~one/week~~ once a week for the period October 1 through April 30 only to protect the PPWS beneficial use.

(b) DEQ may increase the monitoring frequencies listed in (a)(1) and (2) of this Section for a period not to exceed one (1) year during the initial permit cycle for the purpose of establishing the pattern and extent of variation for a given pollutant.

**252:690-3-91. Performance-based monitoring frequency reductions and increases**

(a) ~~Where~~ When MALs ~~are~~ have been established in a previous permit and a parameter(s) has been monitored for one complete permit cycle (five years), performance-based monitoring frequency reductions or increases will be considered.

(1) Except for ammonia, when a permittee has experienced:

(A) no permit limit violation of any kind for a limited parameter during the permit cycle, a performance-based monitoring frequency reduction may be granted according to Table I-1 in Appendix I.

(B) a non-SNC permit limit violation during the permit cycle, the permittee is ineligible for a performance-based monitoring frequency reduction for that parameter for the ensuing permit cycle.

(C) SNC violations for a parameter during the permit cycle, the permittee is:

(i) ineligible for a performance-based monitoring frequency reduction for that parameter for the ensuing permit cycle, and

(ii) a monitoring frequency increase is required in accordance with Table I-2 in Appendix I.

(2) Permittees may request toxicity-based ammonia limit monitoring frequency reductions according to 252:690-3-26 or WET testing frequency reductions according to 252:690-3-42.

(3) The monitoring frequency for a metal may be reduced to once every six (6) months if:

(A) the permit includes a long-term average effluent concentration for the permit cycle of less than ten percent (10%) of the Monthly Average Concentration Limit;

(B) it no longer exhibits reasonable potential (either from monitoring or effluent limit); (C)there is a limit for that parameter in a previous permit that cannot be removed; and

(D) the parameter is not causing the receiving water body to be listed as a Category 5 water body in Oklahoma's Integrated Report.~~Any control test undertaken in accordance with OAC 252:606, Appendix A, shall be reported on the DMRs as required by 40 CFR § 122.41 (l)(4)(ii), provided the control test sample meets all the sample protocol requirements as contained in the OPDES permit. New permitees, or permittees with newly established permit limitations, shall go through one permit cycle (five years) before being eligible for performance-based monitoring frequency reductions or increases. Where a permittee has exhibited SNC for a parameter during the permit cycle, the permittee is ineligible for a performance-based monitoring frequency reduction for that parameter for the ensuing permit cycle, and a monitoring frequency increase is required in accordance with Table I-3. Where a permittee has experienced a permit limit violation of any kind for a limited parameter, short of SNC, during the permit cycle, a performance-based monitoring frequency reduction may be granted according to Table I-1. Where a permittee has experienced no permit limit violation of any kind for a limited parameter during the permit cycle, a performance-based monitoring frequency reduction may be granted according to Table I-2. Permittees may request toxicity-based ammonia limit monitoring frequency reductions according to OAC 252:690-3-26 or WET testing frequency reductions according to OAC 252:690-3-42.~~

(b) Performance-based monitoring frequency reductions shall not be based on a weekly average, a daily minimum or a daily maximum concentration limit.

(c) The permit frequency reductions stated ~~within this rule~~ in this Section and in Appendix I ~~of this Chapter~~ do not affect the need or number of control tests to be undertaken as required in Appendix A of ~~OAC~~ 252:606~~, Appendix A~~. ~~For facilities which have a long-term average effluent concentration for the permit cycle of less than ten percent (10%) of the Monthly Average Concentration Limit and no longer show reasonable potential for a metal (either from monitoring or effluent limit), but have a limit for that parameter in a previous permit that cannot be removed, the monitoring frequency for said parameter may be reduced to once every six (6) months, provided the parameter is not causing the receiving water body to be listed as a Category 5 water body in Oklahoma's Integrated Report.~~

(d) In accordance with 785:45-5-10 and 785:45-5-16, no frequency reduction shall be allowed for bacteriological limitations.

(e) Any control test undertaken in accordance with OAC 252:606, Appendix A, shall be reported on the DMRs as required by 40 CFR § 122.41 (l)(4)(ii), provided the control test sample meets all the sample protocol requirements as contained in the OPDES permit.

## APPENDIX C. METHODOLOGY AND EQUATIONS FOR CHARACTERIZING EFFLUENT AND BACKGROUND CONCENTRATIONS IN DETERMINATION OF REASONABLE POTENTIAL TO EXCEED NUMERICAL CRITERIA [REVOKED]

## APPENDIX C. METHODOLOGY AND EQUATIONS FOR CHARACTERIZING EFFLUENT AND BACKGROUND CONCENTRATIONS IN DETERMINATION OF REASONABLE POTENTIAL TO EXCEED NUMERICAL CRITERIA [NEW]

### I. EFFLUENT

**A. Measures of central tendency.** $C_{E(mean)}$ represents the mean of an effluent distribution. $C_{E(mean)}$ is a geometric mean, unless the geometric mean is not determinable in which case an arithmetic mean is used. Where one or the other form of the mean must be used in an equation, that form is explicitly stated.

(1) **$C_{E(avg)}$.** $C_{E(avg)}$ is calculated as follows:

$$C_{E(avg)} = \frac{\left(\sum_{i=1}^{N} x_i\right)}{N} \qquad \text{[C-1]}$$

(2) **$C_{E(geomean)}$.** $C_{E(geomean)}$ is calculated according to either of the following two forms, which are equivalent.

$$C_{E(geomean)} = \mathrm{EXP}\left(\frac{\left(\sum_{i=1}^{N} \ln(x_i)\right)}{N}\right) = \sqrt[N]{\prod_{i=1}^{N} x_i} \qquad \text{[C-2]}$$

**B. Effluent variability.** An effluent data set's standard deviation is the primary measure of its variability. Generally, as the mean of an effluent distribution increases, its standard deviation also tends to increase. The coefficient of variation is a measure of a data set's variability relative to its arithmetic mean.

(1) **Standard deviation of untransformed effluent data set ($s_x$).** The standard deviation of an untransformed effluent data set is calculated as follows:

$$s_x = \sqrt{\frac{N\sum_{i=1}^{N}\left(x_i^2\right) - \left(\sum_{i=1}^{N} x_i\right)^2}{N(N-1)}}, \qquad \text{[C-3]}$$

where N is the number of data points in the effluent data set.

(2) **Standard deviation of log-transformed effluent data set ($s_{ln(x)}$).** The standard deviation of a log-transformed effluent data set is calculated as follows:

$$s_{\ln(x)} = \sqrt{\frac{N\sum_{i=1}^{N}\left(\ln(x_i)^2\right) - \left(\sum_{i=1}^{N}\ln(x_i)\right)^2}{N(N-1)}}, \qquad [C\text{-}4]$$

where N is the number of data points in the effluent data set.

The standard deviation of a log-transformed data set applies only to the transformed data set and cannot be translated back into an equivalent untransformed data set standard deviation, for example:

$$\mathrm{EXP}\left(s_{\ln(x)}\right) \neq s_x$$

(3) **CV.** The CV of an untransformed data set is calculated as follows, when using at least ten (10) data points (if less than ten (10) data points are available, a value of 0.6 is assumed):

$$CV = \frac{s_x}{C_{E(avg)}}, \qquad [C\text{-}5]$$

where $C_{E(avg)}$ and $s_x$ are determined according to Equations C-1 and C-3, respectively.

**C. $C_{95}$ and $C_{95(M)}$.** The use of both $C_{95}$ and $C_{95(M)}$ assumes a log-normal effluent distribution. For the purpose of determining whether **effluent limitations** are required, $C_{95}$ represents the 95th percentile effluent concentration. For the purpose of determining whether further **effluent monitoring** is required, if $C_{95}$ does not exhibit reasonable potential then $C_{95(M)}$ is used.

(1) **$C_{95}$.** The method by which $C_{95}$ is determined is dependent on whether there are 10or more data points available.

(a) **Less than 10 data points available.** The mean effluent concentration ($C_{E(mean)}$) is multiplied by a reasonable potential factor ($RPF_{95}$), which represents the 95th percentile maximum likelihood estimator for a log-normal distribution, according to Equation C-6. If only one data point is available, it is assumed to represent the effluent mean. $RPF_{95}$ is calculated according to Equation C-7, assuming a CV of 0.6.

$$C_{95} = C_{E(mean)} \times RPF_{95} \qquad [C\text{-}6]$$

$$RPF_{95} = \mathrm{EXP}\left(1.645\sqrt{\ln\left(1+CV^2\right)} - 0.5\ln\left(1+CV^2\right)\right) \qquad [C\text{-}7]$$

Since a CV of 0.6 is assumed, $RPF_{95} = 2.135$ and Equation C-6 reduces to $C_{95} = C_{E(mean)} \times 2.135$. Where determinable, the geometric mean, $C_{E(geomean)}$, shall be used as $C_{E(mean)}$ in Equation C-6. The arithmetic mean, $C_{E(avg)}$, may be used if the geometric mean is unknown or undeterminable.

(b) **Ten or more data points available.** $C_{95}$ is obtained directly from the data set as the inverse of the cumulative log-normal distribution function at a 95% probability using Equation C-8.

$$C_{95} = EXP\left(\ln(x)_{avg} + 1.645 \times s_{\ln(x)}\right) \qquad [C\text{-}8]$$

where $\ln(x)_{avg}$ is the arithmetic mean of the log-transformed effluent data set and $s_{\ln(x)}$ is the standard deviation of the log-transformed effluent data set.

(2) **$C_{95(M)}$.** The smaller the size of an effluent data set, the greater the uncertainty of its distribution. The extreme case occurs where only one data point is available. Where less than 10 data points are available to determine $C_{95}$, further effluent monitoring may be warranted for the purpose of future reevaluation of reasonable potential. The method used, referred to as the TSD method, is described in Section 3.3.2 of Technical Support Document for Water Quality-Based Toxics Control, EPA Publication No. EPA/505/2-90-001, March 1991. A log-normal distribution and a CV of 0.6 are assumed. $C_{95(M)}$ is calculated according to Equation C-9.

$$C_{95(M)} = C_{E(max)} \times RPF_{95(M)} \qquad [C\text{-}9]$$

$C_{E(max)}$ is the highest concentration of a toxicant in its effluent data set. If only one data point is available, it is considered to be $C_{E(max)}$. $RPF_{95(M)}$ is determined at a 95% confidence level and a 95% probability basis, according to Equation C-10.

$$RPF_{95(M)} = \frac{EXP\left(1.645\sqrt{\ln\left(1+CV^2\right)} - 0.5\ln\left(1+CV^2\right)\right)}{EXP\left(z_N\sqrt{\ln\left(1+CV^2\right)} - 0.5\ln\left(1+CV^2\right)\right)} \qquad [C\text{-}10]$$

where $z_N$ is the upper $k^{th}$ percentile of the normal distribution,
$k = (1\text{-confidence level})^{1/N} = (0.05)^{1/N}$ for the 95% confidence level, and
CV=0.6.

Table C-1 lists $RPF_{95(M)}$ values for vales of N from 1 to 9, where CV is assumed to be 0.6.

**Table C-1. $RPF_{95(M)}$ and $z_N$ Values for N<10**

| N | $z_N$ | $RPF_{95(M)}$ |
|---|---|---|
| 1 | -1.645 | 6.199 |
| 2 | -0.760 | 3.795 |
| 3 | -0.336 | 3.000 |
| 4 | -0.068 | 2.585 |
| 5 | 0.124 | 2.324 |
| 6 | 0.272 | 2.141 |
| 7 | 0.390 | 2.006 |
| 8 | 0.489 | 1.898 |
| 9 | 0.574 | 1.811 |

(II) **BACKGROUND ($C_B$).**

**(A) Numerical criteria for toxic substances:** As described in OAC 252:690-3-11 and 14, $C_B$ is the background concentration representative of low stream flow (7Q2) conditions.

**(B) Human health and raw water criteria.** As described in OAC 252:690-3-11 and 15, $C_B$ is the long term background concentration representative of average stream flow conditions, and is expressed as a geometric mean.

**(C) Agriculture criteria.** As described in OAC 252:690-3-11 and 16, if site-specific mineral constituent background data is used (as opposed to the historical YMS and SS criteria in Appendix F of OAC 785:45), $C_B$ is calculated as the arithmetic average of the site-specific background data distribution. If historical YMS and SS data from Appendix F of OAC 785:45 are used, $C_B$ is calculated according to Equation C-11.

$$C_B = 2 \times C_{B(YMS)} - C_{B(SS)} \qquad [C\text{-}11]$$

## APPENDIX I. PERFORMANCE-BASED EFFLUENT MONITORING FREQUENCY REDUCTIONS [REVOKED]

## APPENDIX I. PERFORMANCE-BASED EFFLUENT MONITORING FREQUENCY REDUCTIONS AND INCREASES [NEW]

If a permit contains a monthly average mass loading limit, but not a monthly average concentration limit, the equivalent monthly average concentration limit may be derived from the monthly average mass loading limit and the flow basis (the high 30-day average flow during the previous permit cycle for industrial facilities and the design flow for municipal facilities).

**Table I-1. Performance Based Monitoring Frequency Reductions (No Permit Violations During The Previous Permit Cycle)***

| Baseline Monitoring Frequency (previous permit cycle) | Ratio (Percent) of Long-term Average Effluent Concentration for The Previous Permit Cycle to Monthly Average Concentration Limit [a] | | | | |
|---|---|---|---|---|---|
| | < 25% | ≥25% and <50% | ≥50% and <65% | ≥65% and <75% | ≥75% |
| 7/week (daily) | 2/week | 3/week | 4/week | 5/week | 6/week |
| 6/week | 2/week | 3/week | 3/week | 4/week | 5/week |
| 5/week | 1/week | 2/week | 3/week | 4/week | 4/week |
| 4/week | 1/week | 2/week | 2/week | 3/week | NR |
| 3/week | 1/week | 2/week | 2/week | NR | NR |
| 2/week | 2/month | 1/week | 1/week | NR | NR |
| 1/week | 1/month | 2/month | NR | NR | NR |
| 2/month | 1/month | NR | NR | NR | NR |
| 1/month | NR | NR | NR | NR | NR |
| 1/2 months | NR | NR | NR | NR | NR |

[a] NR means "no reduction."

* The frequency reductions stated in Table I-2 do not affect the need to conduct control tests and do not affect the number of control tests to be conducted. *See*, 252:690-3-91.

**Table I-2. Monitoring Frequency Increases**

| Baseline Monitoring Frequency (previous permit cycle) | Increased Monitoring Frequency for parameters demonstrating a violation during the previous permit cycle [a] |
|---|---|
| 7/week (daily) | NI |
| 6/week | 7/week |
| 5/week | 7/week |
| 4/week | 6/week |
| 3/week | 5/week |
| 2/week | 4/week |
| 1/week | 3/week |
| 2/month | 2/week |
| 1/month | 1/week |
| 1/2 months (every other month) | 2/month |
| 1/3 months (once per quarter) | 1/month |
| 1/6 months (semi-annually) | 1/month |
| 1/year | 1/month |

[a] NI means "no increase"

## APPENDIX J. BACKGROUND MONITORING [REVOKED]

## APPENDIX J. BACKGROUND MONITORING [NEW]

Background monitoring is unnecessary if a BT/C ratio is > 1.0. The maximum BT/C ratio for which background monitoring is required, which decreases as the value of the associated criterion increases, is expressed by Equations J-1, J-2 and J-3.

$(BT/C)_{max} = 1.0$, where the criterion ≤ 1.0 μg/l. [J-1]

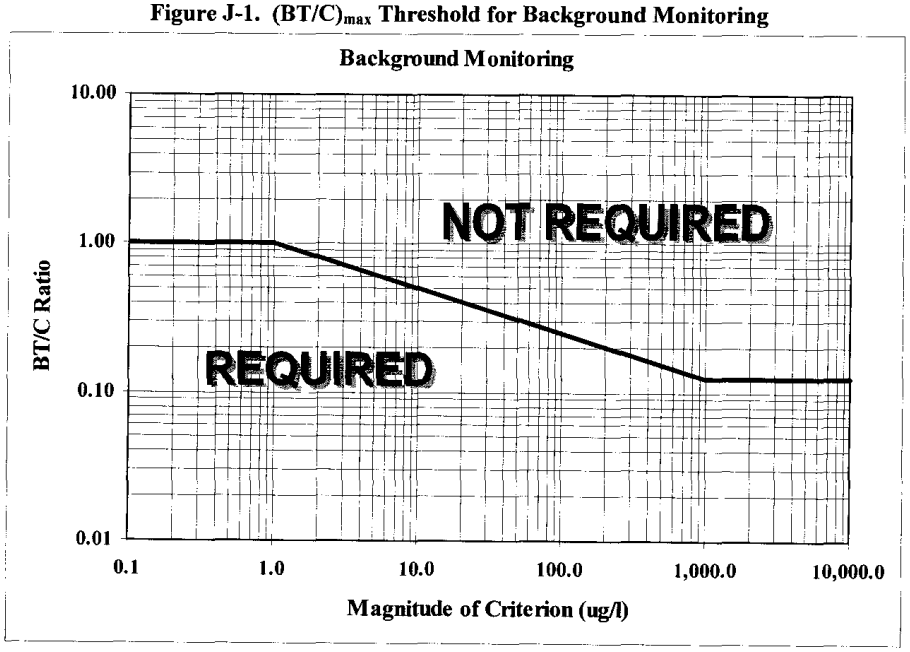
$(BT/C)_{max} = \frac{1}{2^{\log(\text{criterion})}}$, where the criterion > 1.0 μg/l and ≤ 1000 μg/l. [J-2]

$(BT/C)_{max} = 0.125$, where the criterion > 1000 μg/l. [J-3]

If the BT/C ratio ≤ $(BT/C)_{max}$, then background monitoring is required.

The relationship between criterion magnitude and $(BT/C)_{max}$, and under what conditions that background monitoring is required is illustrated in Figure J-1.

**Figure J-1. $(BT/C)_{max}$ Threshold for Background Monitoring**




*[OAR Docket #13-786; filed 5-16-13]*

# TITLE 260. ~~OFFICE OF STATE FINANCE~~OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
# CHAPTER 1. ADMINISTRATIVE OPERATIONS

*[OAR Docket #13-925]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
260:1-1-1. Purpose [AMENDED]
260:1-1-2. Chief administrative officer [AMENDED]
260:1-1-3. Availability of records [AMENDED]
260:1-1-4. Organization of the ~~Office of State Finance~~Office of Management and Enterprise Services [AMENDED]
260:1-1-5. Appeals [AMENDED]
**AUTHORITY:**
Office of Management and Enterprise Services; 62. O.S. §34.28; 62 O.S. §34.3.1; 74 O.S. §1304.1; 74 O.S. §1305.1; §1308.1(1) and §1332(A).
**DATES:**
**Comment Period:**
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May 6, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 24, 2013
**Final adoption:**
May 24, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
None
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed rule changes are the result of state legislation that consolidates, reorganizes, and renames certain state agencies and entities.
**CONTACT PERSON:**
Gary Goff, Deputy General Counsel, (405) 717-8744

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### 260:1-1-1. Purpose

(a) The ~~Office of State Finance (also referred to as OSF)~~Office of Management and Enterprise Services (also referred to as OMES) is created by Section ~~41.3~~34.3 of Title 62 of the Oklahoma Statutes.
(b) The primary statutory powers and duties of ~~OSF~~OMES are set forth in Section ~~41.1~~34.2 et seq of Title 62 of the Oklahoma Statutes.
(c) The principal office of the ~~Office of State Finance~~Office of Management and Enterprise Services is located in the State Capitol, 2300 N Lincoln Boulevard, Suite 122, Oklahoma City, Oklahoma.
(d) Office hours are from 8:00 a.m. to 5:00 p.m. each day, except Saturday and Sunday, and any legal holiday established by statute or proclamation of the Governor.

### 260:1-1-2. Chief administrative officer

(a) The Director of ~~State Finance~~the Office of Management and Enterprise Services is the chief administrative officer of the ~~Office of State Finance~~Office of Management and Enterprise Services and is responsible for providing the overall direction necessary for the agency to attain its mission as established by statute or administrative rule.
(b) The Director of ~~State Finance~~the Office of Management and Enterprise Services is appointed by the Governor, by and with the consent of the Senate, and serves at the pleasure of the Governor (62 O.S. § Section ~~41.2~~34.5).

### 260:1-1-3. Availability of records

(a) Records in the custody of ~~OSF~~OMES, except those documents specifically excluded by law, shall be available to the public as provided by the Open Records Act. Documents will be available to the public for inspection during regular office hours.
(b) Persons wishing to view records of ~~OSF~~OMES shall register their name, address and telephone number before documents are viewed. The registrant shall state whether the documents are being viewed for a personal, business or commercial reason and shall list the documents desired for viewing.
(c) No original records shall be removed from ~~OSF~~OMES.
(d) Persons wishing to photocopy documents in the custody of ~~the OSF~~OMES may do so in accordance with the Open Records Act. A charge for copies may be made in accordance with the Open Records Act and administrative rules of ~~the OSF~~OMES.

### 260:1-1-4. Organization of the ~~Office of State Finance~~Office of Management and Enterprise Services

The ~~Office of State Finance~~Office of Management and Enterprise Services is organized to include the following Divisions: ~~Division of the Budget, Division of Central Accounting and Reporting, an Information Services Division, and an Oklahoma Financial Information Management System Division.~~Central Purchasing, Division of Budget, Policy and Communications, Division of Capital Assets Management (DCAM), Division of Central Accounting and Reporting, Employees Group Insurance Division (EGID), Human Capital Management (HCM), and Information Services Division (ISD).

**260:1-1-5. Appeals**

Any decision of the ~~Office of State Finance~~Office of Management and Enterprise Services may be appealed in accordance with the Oklahoma Administrative Procedures Act. Appeals must be submitted in writing to the Director of ~~State Finance~~the Office of Management and Enterprise Services at the principal office of the ~~Office of State Finance~~Office of Management and Enterprise Services within ten (10) days of notification of decision.

*[OAR Docket #13-925; filed 5-24-13]*

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## TITLE 260. ~~OFFICE OF STATE FINANCE~~OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
## CHAPTER 10. PROMPT PAYMENT TO VENDORS AND EMPLOYEES OF THE STATE OF OKLAHOMA THROUGH THE PAYMENT OF INTEREST ON LATE PAYMENTS

*[OAR Docket #13-926]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
subchapter 1. General provisions
260:10-1-1. Purpose [AMENDED]
260:10-1-2. Definitions [AMENDED]
260:10-1-3. Scope [AMENDED]
Subchapter 3. Vendor and Employee Interest Claim Procedures
260:10-3-1. Agency Payments [AMENDED]
260:10-3-3. Calculation of interest [AMENDED]
260:10-3-7. Invoices [AMENDED]
**AUTHORITY:**
Office of Management and Enterprise Services; 2. O.S. §34.28; 62 O.S. §34.3.1; 74 O.S. §1304.1; 74 O.S. §1305.1; §1308.1(1) and §1332(A).
**DATES:**
**Comment Period:**
February 15, 2013 through March 18, 2013
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March 18, 2013
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**Submitted to Governor:**
April 1, 2013
**Submitted to House:**
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**Submitted to Senate:**
April 1, 2013
**Gubernatorial approval:**
May 6, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 24, 2013
**Final adoption:**
May 24, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
None
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed rule changes are the result of state legislation that consolidates, reorganizes, and renames certain state agencies and entities.
**CONTACT PERSON:**
Gary Goff, Deputy General Counsel, (405) 717-8744

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 1. GENERAL PROVISIONS

**260:10-1-1. Purpose**

(a) ~~Enrolled House Joint Resolution 1010, 1st Session, 39th Legislature, and Enrolled House Bill 1905, 2nd Session, 40th Oklahoma Legislature, confirmed that it~~It is the policy of the State of Oklahoma to promptly pay for the goods and services purchased by and delivered to the various agencies, boards, commissions, and institutions of this State, and travel expenses incurred by employees of this State upon good faith presentation of sufficient claims for the sums due and owing. To this end, the Director of ~~State Finance~~the Office of Management and Enterprise Services is directed to establish procedures to expedite payment of proper invoices and travel claims and to provider for the payment of interest on proper invoices and claims for reimbursement for cost of travel incurred by state employees which are not paid by an agency, board, commission, or institution within forty-five (45) days of receipt by the appropriate office of such State entity. [62 O.S. §§34.71, 34.72; 74 O.S. §500.16A]

(b) The procedure to expedite payment has been determined by the Director to involve only internal procedures of the ~~Office of State Finance~~Office of Management and Enterprise Services, or of the agencies subject to the ~~Resolution~~statutes, ~~and under the jurisdiction of the Director of Public Affairs,~~and thereby not appropriate for rulemaking under Title 75 of the Oklahoma Statutes, Section 250 et seq. Payment of interest to a vendor and employee of the state who is aggrieved by delay in payment beyond the forty-five (45) day limit does affect a private right of citizens of Oklahoma who do business with the State and is quite appropriately the subject of rulemaking. The rules of this chapter set forth the limitations, time frames and guidelines for vendor and employee claims for payment of interest on late payment.

**260:10-1-2. Definitions**

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

**"Agency"** means any department, office, board, commission or institution of the State.

**"Director"** means the Director of ~~State Finance~~the Office of Management and Enterprise Services.

**"Employee"** means any individual whose reimbursement for travel expense is computed and subject to the State Travel Reimbursement Act, except:

(A) Those individuals due compensation for travel or other services subject to the Central Purchasing Act.

(B) Individuals providing services to the state for which compensation is not paid on a payroll including volunteers and/or recipients of public assistance programs.

**"Make payment"** means to mail, transmit, or deliver settlement to a vendor.

**"Proper claims"** means any individual whose reimbursement for incurred expenses for travel supported by all requisite documentation and complete in all respects for processing for payment, in accordance with the State Travel Reimbursement Act, and covers periods of travel beginning November 1, 1986, or later.

**"Proper invoice"** means any invoice which is complete in all requirements for processing for payment in accordance with the terms of appropriate contracts or purchase orders and applicable State or Federal statutes, including but not limited to such documentation as may be required. This definition shall include properly documented, standard, notarized claim forms, commonly known as "Form 3 Claims."

**"Receipt of a proper claim"** means actual receipt of the proper claim by the first office or official in an agency where the employee is required to submit the claim, by agency procedures, to obtain reimbursement for travel expenses.

**"Receipt of a proper invoice"** means actual receipt of the proper invoice by the payment office designated by the agency in appropriate contracts or purchase orders.

**"Vendor"** means any supplier of goods or services to the State, except:

(A) employees of the State for payroll, travel, or other reimbursement purposes;

(B) recipients of entitlement or benefit payments;

(C) recipients of grant funds from agencies who are acting as the administrative vehicle by which the grant funds are passed through to the grantee; and

(D) vendors providing goods or services in conjunction with public construction are specifically excluded from these procedures.

**260:10-1-3. Scope**

(a) The laws of Oklahoma, at 61 O.S. 1981, Section 101 et seq., the "Public Competitive Bidding Act of 1974,"as amended, provide specific legislative direction when interest is appropriate on claims under public construction contracts. Contracts executed prior to November 1, 1983, may contain express "interest," provisions which are at variance with the procedures developed pursuant to 62 O.S. Section ~~41.4(a)~~34.71 et seq. (See for example, Attorney General Opinion No. 83-120). Accordingly, only payments under contracts bid and awarded after November 1, 1983, are encompassed by the procedures promulgated under the authority conferred by 62 O.S., Section ~~41.4(a)~~34.71 et seq.

(b) This chapter is not intended to ~~supercede~~supersede or replace other Federal or State statutes regarding interest, nor statutes prohibiting interest on late payments, nor judgments or settlements that provide for payment of interest.

(c) The Director, in concert with the State Treasurer, ~~and Director of Public Affairs,~~ shall make continuing studies of policies and procedures of these central offices, make changes when necessary to modernize systems with emphasis in expediting procurement, claim settlement, and warrant issuing, and, when appropriate, recommend changes to existing laws or proper new laws to accomplish this end.

## SUBCHAPTER 3. VENDOR AND EMPLOYEE INTEREST CLAIM PROCEDURES

**260:10-3-1. Agency Payments**

Agencies shall implement internal procedures to insure that they will make payment to vendors or employees within forty-five (45) days of receipt of a proper invoice or proper claim. If an agency fails to make payment within the forty-five (45) days, the vendor or employee shall be entitled to claim interest.

**260:10-3-3. Calculation of interest**

The rate of interest for failure of an agency to make payment as specified in 260:10-3-1 shall be based on the per annum, computed on a 360-day calendar, per $100 per day. The rate of interest ~~may change~~normally changes on July 1st of each year depending on the average interest rate for thirty day time deposits of State funds during the last calendar quarter of the last preceding fiscal year. The rate of interest shall be computed on a 360-day calendar. The State Treasurer shall report to the Director on July 1st of each year what the average interest rate was for the previous calendar quarter. The Director shall notify all agencies and ~~vendors who are in the office of Public Affairs bidder file as to~~publish on the OMES website what the interest rate shall be for the next fiscal year beginning July 1st.

**260:10-3-7. Invoices**

An agency shall have ten (10) working days to notify or return to a vendor or employee an improper invoice or improper claim; otherwise, the clock will start to run as provided in 260:10-3-2~~(a)~~(1), as if the agency had received a proper invoice or proper claim. This also applies to invoices for interest claimed by a vendor or employee as provided in 260:10-3-4.

*[OAR Docket #13-926; filed 5-24-13]*

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## TITLE 260. ~~OFFICE OF STATE FINANCE~~OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
## CHAPTER 15. ACCESSIBILITY OF INFORMATION TECHNOLOGY

*[OAR Docket #13-927]*

**RULEMAKING ACTION:**

PERMANENT final adoption

**RULES:**
260:15-1-1. Purpose [AMENDED]
260:15-1-2. Definitions [AMENDED]
260:15-1-3. Information technology accessibility standards [AMENDED]
260:15-1-5 Accessibility compliance representative [AMENDED]
260:15-1-6. Filing a formal complaint [AMENDED]
260:15-1-7. Processing a complaint [AMENDED]
260:15-1-8. Disagreement with final complaint response [AMENDED]
260:15-1-9. Annual complaint report [AMENDED]
**AUTHORITY:**
Office of Management and Enterprise Services; 62. O.S. §34.28; 62 O.S. §34.3.1; 74 O.S. §1304.1; 74 O.S. §1305.1; §1308.1(1) and §1332(A).
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None
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed rule changes are the result of state legislation that consolidates, reorganizes, and renames certain state agencies and entities.
**CONTACT PERSON:**
Gary Goff, Deputy General Counsel, (405) 717-8744

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### 260:15-1-1. Purpose

This chapter provides information and establishes procedures to assure state compliance regarding accessibility of information technology for individuals with disabilities based on the provision of Title 62, Section ~~41.5t~~34.28 and Section 508 of the Rehabilitation Act (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 (P.L. 105-220), August 7, 1998.

### 260:15-1-2. Definitions

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

**"Accessibility"** means compliance with nationally accepted accessibility and usability standards, such as those established in Section 508 of the Rehabilitation Act (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 (P.L. 105-220), August 7, 1998;

**"Appointing authority"** means the chief administrative officer of an agency. As the term is used in this chapter, the term includes employees of an agency to whom the Appointing Authority has lawfully delegated authority to act on his or her behalf.

**"Director"** means the Director of the ~~Office of State Finance~~Office of Management and Enterprise Services.

**"Individual with Disabilities"** means any individual who is considered to have a disability or handicap for the purposes of any Federal or Oklahoma law.

**"Information Technology"** or **"IT"** means equipment or interconnected system or subsystem of equipment that is used in the acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, telecommunications, or reception of data or information. The term shall include computers, ancillary equipment, software, firmware, and similar procedures, services, including support services and consulting services, software development, and related resources.

**"Oklahoma Information Technology Accessibility Standards"** or **"IT Accessibility Standards"** or **"Standards"** means the accessibility standards adopted by the ~~Office of State Finance~~Office of Management and Enterprise Services together with the ~~Department of Central Services~~Division of Capital Assets Management, to address all technical standard categories based on the provisions of Section 508 of the Workforce Investment Act of 1998, which are to be used by each state agency in the procurement of information technology, and in the development and implementation of custom-designed information technology systems, web sites, and other emerging information technology systems.

**"Section 508"** means Section 508 of the Rehabilitation Act (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 (P.L. 105-220), August 7, 1998.

**"State agency"** means any office, officer, bureau, board, counsel, court, commission, institution, unit, division, body or house of the executive or judicial branches of the state government, whether elected or appointed, excluding political subdivisions of the state. State agency shall include the Oklahoma State Regents for Higher Education, the institutions, centers, or other constituent agencies of The Oklahoma State System of Higher Education, the State Board of Career and Technology Education and Technology Center school districts. [62 O.S., Section ~~41.5t.1~~34.28]

### 260:15-1-3. Information technology accessibility standards

(a) The ~~Office of State Finance~~Office of Management and Enterprise Services shall prescribe Information Technology Accessibility Standards to address all technical standard categories of Section 508 in accordance with 62 O.S. §34.28. Information technology products covered by these standards shall comply with all applicable provisions. When developing, procuring, maintaining or using information technology products (either directly or through administration of contracts or grants), each state agency, as defined in this Chapter, shall

ensure that the products comply with these all applicable standards, unless an undue burden would be imposed on the agency. ~~or an exception pursuant to OAC 580:15-6-24 exists.~~

(b) These standards are effective September 1, 2005 and apply to all information technology procured, developed and/or substantially modified or substantially enhanced after the effective date of these standards, providing the procurement and/or development process was not initiated prior to the effective date.

(c) The Information Services Division shall maintain the IT Accessibility Standards.

(d) The Standards will be made available to the public at the principal office of the ~~Office of State Finance~~Office of Management and Enterprise Services and the ~~Department of Central Services~~Division of Capital Assets Management and shall be published on their respective websites.

(e) When compliance with these standards imposes an undue burden, agencies shall provide individuals with disabilities the information and data involved by an alternative means of access that allows the individual to use the information and data in accordance with other applicable State and Federal laws such as Title I and Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

**260:15-1-5. Accessibility compliance representative**

(a) The Appointing authority in each state agency shall designate an Accessibility Compliance Representative(s) to:

(1) Ensure all electronic and information technology produced, procured, or developed by the agency is accessible to the disabled;

(2) Receive, investigate and process formal complaints alleging the agency's failure to comply with electronic and information technology accessibility laws, rules and/or standards;

(3) Assist complainants to ensure a complaint is clear and complies with this Chapter;

(4) Upon receipt of a formal complaint, thoroughly investigate other instances of similar accessibility issues in related systems within the agency.

(5) Annually execute a certified statement assuring compliance with state Standards and submit to the Information Services Division with the long-range plan prescribed by the ~~Office of State Finance~~Office of Management and Enterprise Services in accordance with 62 O.S. Section ~~41.5e~~34.16.

(b) The name and contact information of the designated Accessibility Compliance Representative shall be filed and updated, whenever necessary, with the ~~Office of State Finance~~Office of Management and Enterprise Services, ~~Department of Central Services~~Division of Capital Assets Management and Oklahoma ABLE Tech.

(c) The name and contact information of the Accessibility Compliance Representative shall be published on the agency website.

**260:15-1-6. Filing a formal complaint**

(a) Effective one (1) year after the effective date of this Chapter, any individual may file a complaint alleging that a state agency or its authorized agent does not comply with electronic and information technology accessibility laws or the Information Technology Accessibility Standards.

(b) The written complaint shall be filed with the agency responsible for the information technology in question.

(c) The written complaint must:

(1) State the name, contact address and telephone number of the complainant;

(2) Identify the information technology in question; and,

(3) Describe the non-conformance with the IT Accessibility standards in sufficient detail as to allow a thorough investigation.

(d) The agency Accessibility Compliance Representative will review the complaint, and when necessary, work with the complainant to ensure the complaint is clear and is addressed by the IT Accessibility Standards.

**260:15-1-7. Processing a complaint**

(a) Upon receipt, the agency Accessibility Compliance Representative will review the complaint to determine whether the technology listed in the complaint is subject to the IT Accessibility Standards.

(b) The Accessibility Compliance Representative will send a written notice to the complainant within ten (10) business days, excluding holidays, from the receipt of the written complaint, which will include:

(1) a statement indicating whether the technology in question is or is not subject to the IT Accessibility Standards;

(2) a statement that the agency will conduct a review to confirm whether the technology in question is non-compliant, if the technology in question has been determined to be subject to the IT Accessibility Standards; and

(3) a copy of these complaint procedures.

(c) The Accessibility Compliance Representative will conduct a review within thirty (30) days from the receipt of the written complaint to determine whether the technology in question is non-compliant. The Information Services Director, ~~Office of State Finance~~the Office of Management and Enterprise Services may assist with the review, if necessary.

(d) Upon completion of the review, the agency shall provide written notice of the results of the review to the complainant and the ~~Office of State Finance~~Office of Management and Enterprise Services, which shall include one of the following:

(1) Documentation that the technology conforms to all applicable Standards;

(2) A documented explanation that any non conformance with the Standards was exempted due to an exception or undue burden; or

(3) An agreement in part or in whole with the written complaint that includes a plan with reasonable timelines for conforming to applicable IT Accessibility Standards.

**260:15-1-8. Disagreement with final complaint response**

(a) If a complainant is not satisfied with the final complaint response issued by an agency, a complaint may be refiled with the agency or with the Information Services Director of the ~~Office of State Finance (OSF)~~Office of Management and Enterprise Services (OMES).

(b) Whenever a complaint is filed with ~~OSF~~OMES and the EITA Advisory Council pursuant to this section, a review team will convene to review the complaint and the agency response. Members of this team shall include a representative of the IT Services Division of ~~OSF~~OMES, a representative of Oklahoma ABLE Tech and may include additional members with technical expertise needed to determine conformance with the Standards.

(c) Written notice of receipt of a complaint pursuant to this section shall be sent to the complainant, within ten (10) business days, excluding holidays, from the date the complaint is filed.

(d) The review team shall evaluate the complaint and the agency response and may gather additional information as necessary to render an independent decision.

(1) If the review team determines the technology does not comply with IT Accessibility Standards, the team shall send written notice to the agency of such findings and request a plan of resolution including timelines.

(2) The team shall also send written notice of their findings to the complainant and the agency indicating an agreement or disagreement with the agency's initial complaint response. If the technology in question is out of compliance, the written notice shall also include a copy of the agency's plan for resolution.

(e) The review team must conclude this review and send the final written notice to the complainant and the agency no later than sixty (60) calendar days from the receipt of the written complaint with the ~~Office of State Finance~~Office of Management and Enterprise Services.

(f) Any actions, decisions or individual proceedings that may occur as a result of a formal complaint shall be in accordance with 75 O.S. §250 et seq.

**260:15-1-9. Annual complaint report**

The appointing authority shall maintain summary and statistical information about the number, nature and outcome of all formal complaints filed. A complaint report containing such information shall be provided to the ~~Office of State Finance~~Office of Management and Enterprise Services on October 1 each year.

*[OAR Docket #13-927; filed 5-24-13]*

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## TITLE 300. GRAND RIVER DAM AUTHORITY
## CHAPTER 20. PURCHASING POLICY

*[OAR Docket #13-930]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
300:20-1-1. [AMENDED]
300:20-1-2. [AMENDED]
300:20-1-3. [AMENDED]
300:20-1-4. [AMENDED]
300:20-1-8. [AMENDED]
300:20-1-10. [AMENDED]
300:20-1-11. [REVOKED]
300:20-1-12. [AMENDED]
300:20-1-13. [AMENDED]
300:20-1-14. [AMENDED]
300:20-1-15. [AMENDED]
300:20-1-16. [REVOKED]
300:20-1-17. [NEW]
**AUTHORITY:**
Grand River Dam Authority; 82 O.S. 2010, § 861A(B)(1); 82 O.S.Supp. 2012, § 863.2(B).
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N/A
**ANALYSIS:**
The rules specify procedures concerning purchases for repair, construction or improvements to Grand River Dam Authority ("GRDA") facilities or land governed by Title 61 of the Oklahoma Statutes. Clarifications have been made to acquisitions and expenditures which are exempt from the competitive bidding processes. Language has been included to more specifically define an "emergency" for allowance of emergency acquisitions. The General Manager shall have authority to approve acquisitions as may be delegated by the Board of Directors. Further, the General Manager may delegate acquisition approval to other GRDA employees and determine the monetary threshold for mandatory competitively bid purchases, subject to approval by the Board of Directors. Clarifications have been made to allowable business expenses. Other general clarifications have been made and duplicative language has been removed. A new section regarding approvals for advanced payments is included.
**CONTACT PERSON:**
Ellen Caslavka Edwards, General Counsel, Grand River Dam Authority, P.O. Box 409, Vinita, OK 74301, (918) 256-0800.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED**

**FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

**300:20-1-1. Introduction to purchasing ~~policy~~rules**

(a) **General.** ~~The material contained herein is designed to~~These rules explain and facilitate understanding of ~~the Central Purchasing Unit and~~ the Authority's functions~~, policies and procedures~~ related to purchasing~~ other than those contracts in excess of $50,000.00 which concern the repair, construction or improvements to GRDA facilities or land. This policy does not apply to acquisitions of professional services as defined in Section 803 of Title 18, as well as power capacity, energy, transmission and ancillary services, governmental relations or business expense acquisitions described in Section 300:20-1-15(c) or employee training or conference registration acquisitions. Such acquisitions shall be exempt from competitive bidding procedures. The acquisition of coal and natural gas, and the delivery of same, may be confidential and therefore the bidding process may deviate from the guidelines set forth herein.~~

~~(b) The included policy statements represent the basic intentions and goals of the GRDA Board of Directors~~.

(~~c~~b) **Application of the rules.** ~~The procedures set forth~~These rules are expressly designed to implement the Board's policy and state law. Procedures will conform to changes in ~~policy~~rule or law and when necessary, procedures will be modified ~~on an "as needed basis"~~ to refine the purchasing process. These rules shall apply to all GRDA purchases except where noted otherwise herein. These rules do not apply to repairs, construction, or improvements to GRDA facilities or land that are governed by Title 61 of the Oklahoma Statutes.

(c) **Repairs, construction, or improvements to GRDA facilities and land.** For purchases for repair, construction or improvements to GRDA facilities or land that are governed by the provisions of Title 61 of the Oklahoma Statutes, GRDA will utilize forms and processes comparable to those prescribed by the Office of Management and Enterprise Services ("OMES") Construction and Properties Division. Where the provisions of Title 61 and the rules promulgated thereunder refer to the "Construction and Properties Division" the GRDA Central Purchasing Unit shall perform the duties of the OMES Construction and Properties Division for GRDA purchases when GRDA is allowed under Title 61 to perform such processes or assume such responsibilities. Where the provisions of Title 61 or related administrative rules applicable thereto refer to the "Construction and Properties Division Administrator" or "Administrator" the employee designated by the GRDA Chief Financial Officer shall assume such responsibilities, in instances where the Construction and Properties Division has delegated such authority to state agencies or GRDA.

(d) **Exempt from competitive bidding processes.** Acquisitions of professional services as defined in Section 803 of Title 18 or acquisitions pursuant to the Oklahoma State Interlocal Cooperation Act, as well as power capacity, energy, transmission and ancillary services, insurance, banking, government relations or business expense acquisitions described in Section 300:20-1-15(c), employee training, conference registration, or utility acquisitions are exempt from the competitive bidding processes described herein. Similarly, the acquisition of coal, natural gas, or other energy resources may be confidential or may require special acquisition processes. Therefore the selection of vendors for these products or services may deviate from the guidelines set forth herein.

(~~d~~e) **Definitions**

(1) **Acquisition.** The process of obtaining items, products, materials, supplies, services (including construction), and equipment by purchase, lease-purchase, lease with option to purchase or rental pursuant to the GRDA Purchasing Policy and Procedures and applicable State laws and directives.

(2) **Acquisition approval or signature authority.** The approval delegated by the Board of Directors or General Manager for a GRDA employee to approve a purchase order or resulting payment thereof.

(~~2~~3) **Bid.** ~~A complete and properly authorized proposal or quote from a vendor or supplier to provide goods, commodities, services, or designated portions for the sums stated and submitted in accordance with solicitation documents.~~The cost proposal submitted by a vendor in response to a request or solicitation from the GRDA for a project described in plans and/or specifications provided by GRDA.

(4) **Board of directors.** The rule-making authority and governing body of the Grand River Dam Authority as defined by 82 O.S. § 863.2.

(~~3~~5) **Central purchasing unit.** The specialist unit within the GRDA Finance Department that is responsible for supervising and managing the acquisitions of materials, supplies, and services that are used by the Authority and for administering procurement policies, rules, and procedures.

(~~4~~6) **Emergency acquisition.** An acquisition made without following normal acquisition procedures in order to obtain goods or services to meet an urgent and unexpected requirement. An "Emergency" shall be identified as: an event that consists of one or more of the following:

(A) Correction of an immediate hazardous condition which affects the safety of personnel or the public health;

(B) Prevention of immediate damage to property or the reduction in reliability of electric generating equipment;

(C) Avoidance of purchase of alternative power to replace otherwise generated power;

(D) Maintenance of the efficient and orderly completion of work-in-progress;

(E) Correction of an immediate regulatory compliance deficiency;

(F) To obtain needed items when market conditions (e.g. natural disaster, terrorist act, etc.) limit the product or service availability, or when vendors may not be able to quote firm prices as would be possible under normal market conditions;

(G) To prevent or minimize the serious disruption of services to customers;

(H) To keep facilities operating, to ensure continuous transmission service, or when a Board meeting has been cancelled and thus it is necessary to avoid disruption of the purchasing process when a bid may expire prior to the next regularly scheduled Board meeting;

(I) Emergency acquisitions made pursuant to Title 61 of the Oklahoma Statutes.

~~(5) **Policies.** Policies, as referred to herein, are pre-decisions made by Management and the Board of Directors for the purpose of giving information and direction. Policies establish basic philosophies and climates, and determine the major values upon which the Purchasing function must operate.~~

(7) **General manager or chief executive officer.** The GRDA employee who has oversight and managerial responsibility over all GRDA functions and is selected by the Board of Directors of the Grand River Dam Authority as authorized by 82 O.S. § 864.A.2.

(8) **GRDA or authority.** The Grand River Dam Authority, a governmental agency of the State of Oklahoma, as defined by 82 § 816, et seq.

(9) **Low Dollar Purchase.** A purchase for goods or services that does not exceed the competitive bid dollar threshold as determined by the General Manager.

(~~6~~10) **Procedures.** Procedures are the prescribed means of ~~accomplishing policy~~complying with the applicable statutes and rules. ~~Their intent is to~~Procedures provide GRDA personnel with the guidelines and, where appropriate, specific action sequences to ensure uniformity, compliance and control of all policy-related activities..

(~~(7)~~(11)) **Solicitation.** An invitation for bids, a request for proposal, telephone calls, or any document or method used to obtain bids or proposals for the purpose of entering into a contract.

**300:20-1-2. Purpose**

The ~~overall policy goal~~purpose of the Authority's acquisition practices is to maintain, at all times, a continuous supply of goods and services necessary to support GRDA's operations. ~~Individual aspects of this policy are~~The Authority shall:

(1) ~~To comply~~Comply with~~, in all aspects and without qualification or evasion,~~ the laws of the State of Oklahoma and the GRDA Bylaws governing policy and procedures for acquisitions.

(2) ~~To ensure~~Ensure the uninterrupted flow of production by obtaining and ensuring delivery of an acceptable quality of goods and services at the maximum end-use value per dollar spent.

(3) ~~The management of~~Manage inventories of acquired goods so as to meet the use requirements of all GRDA departments at the lowest possible cost.

(4) ~~To treat~~Treat all prices, technical information, and other bidder information submitted by suppliers as confidential until ~~after bid openings in order to preserve a good business reputation and obtain competitive pricing~~after a supplier is selected and the contract is awarded.

(5) ~~The amicable resolution of~~Amicably resolve complaints on all purchased goods and services.

**300:20-1-3. Scope**

These ~~policies~~rules apply to all Board members, officers, and employees of the Authority, and to all those persons or entities doing business or seeking to do business with the Authority.

**300:20-1-4. Responsibilities**

(a) The Board of Directors is ~~primarily~~ responsible for promulgating ~~a~~ comprehensive Purchasing ~~Policy~~Rules, and for approving or delegating approval of acquisitions ~~above $50,000.00~~.

(b) The General Manager shall have authority to approve acquisitions ~~in excess of $5,000 but not more than $50,000 or delegate an approval threshold for such acquisitions to the Chief Operating Officer not to exceed $50,000~~as may be delegated by the Board of Directors.

(c) ~~The~~Subject to the approval of the Board of Directors, the General Manager may delegate acquisition approval ~~not to exceed $5,000.00~~ to ~~any employee~~other employees of the Authority and determine the dollar threshold for purchases that must be competitively bid.

(d) The Central Purchasing Unit has the responsibility for obligating the Authority and for making the final determination of source of supply, ultimate quantities purchased, delivery schedule, price, and commercial terms. These decisions will be made in conjunction with other departments as appropriate.

(e) The Central Purchasing Unit is to serve as the exclusive channel through which all requests regarding prices and products are handled. This Unit and no other ~~will~~shall conduct all communications with suppliers involving prices or quotations. Close communication and coordination between the Central Purchasing Unit and the department requesting supplies must occur. The General Manager is responsible for determining the dollar threshold for those purchases that may be competitively bid by departments or units of the Authority outside of the Central Purchasing Unit. Subsections (d) and (e) do not apply to emergency acquisitions and ~~small~~low-dollar purchases ~~that do not exceed $5,000.00~~or purchases competitively bid by departments, units, or employees other than the Central Purchasing Unit.

(f) The Chief Financial Officer or designee is responsible for maintaining a uniform set of procedures and forms to service the competitive bid process in accordance with the dollar thresholds determined by the General Manager, the process for non-competitive acquisitions (sole source, sole brand, State Use, etc.), and other acquisition matters, including, but not limited to, evaluation, award, change orders, contract administration, or disputes. These procedures shall be submitted to the Board of Directors for review. Central Purchasing Unit personnel and any other designated department, unit, or personnel are responsible for obtaining bids on all material or services covered under these rules as described herein or the internal uniform procedures.

(~~f~~g) The Central Purchasing Unit with the approval of the General Manager may develop, test, and implement new or alternative acquisition procedures and practices that hold potential for making the Authority's acquisition process more effective and efficient or to be consistent with industry practices. Examples of such acquisition procedures and practices may include, but not be limited to, contract negotiations, reverse auctioning, electronic commerce for online solicitations, notifications, and award. If such practices substantially vary with any procedures herein, the General Manager will notify the Board of such variances on the monthly Purchase Order report provided to the Board~~ for such acquisitions that exceed $50,000~~.

**300:20-1-8. State of Oklahoma statewide and state use contracts**

Non-mandatory statewide contracts awarded by the ~~Department of Central Services (DCS)~~OMES, for use by certain local governments and state agencies may be utilized by GRDA. Statewide Contracts may be used when use of these contracts would result in a more efficient acquisition process or when the end result is timely delivery of an acceptable quality of goods and services. Those preparing requisitions should also consider other contracts (e.g., multistate, multi-governmental, multi-utility, etc.) when such contracts may be beneficial to GRDA. GRDA must also comply with the applicable provisions statutes and administrative rules related to the State Use Committee.

**300:20-1-10. Requisition review**

This section applies to all ordinary acquisitions ~~in excess of $5,000, or any acquisition, regardless of amount, that is purchased in accordance with the provisions of 300:20-1-8~~that are to be competitively bid. The ~~Central Purchasing Unit~~GRDA employee soliciting bids shall have the responsibility and authority to review specifications and sources within the following guidelines:

(1) The user and the ~~Central Purchasing Unit shall be jointly~~GRDA employee soliciting bids are responsible for developing a list of acceptable vendors of a specific product or service whenever necessary~~. Once a list of acceptable vendors has been established, the Central Purchasing Unit~~and shall be responsible for the selection of a vendor or vendors from that list~~ who can best respond to the requirements of each particular order~~.

(2) The ~~Central Purchasing Unit~~GRDA employee soliciting bids shall review the specifications of each acquisition requisition. The review shall include: requests for "sole source or sole brand" acquisitions; requests for goods of a quality or quantity that seem to be greater or less than required; requests that do not conform to Authority standards; and requests without proper authorization. Buyers shall not materially alter specifications without discussion with the requestor.

(3) Requisitions which do not contain enough specific information will be returned to the requestor for further attention.

**300:20-1-11. Responsibilities, delegation, source selection, evaluations, and disputes [REVOKED]**

~~(a) The acquisition process is primarily the responsibility of the Central Purchasing Unit and requires consideration of several factors. In managing the acquisition process, the Central Purchasing Unit will coordinate closely with departments to comply with applicable acquisition requirements and standards. The user departments play a key role in the acquisition process by developing adequate and reasonable specifications for each acquisition. Those specifications shall be submitted to and reviewed by the Central Purchasing Unit.~~

~~(b) The Chief Financial Officer or designee has the responsibility of maintaining a uniform set of procedures and forms to service the bid process, the process for non-competitive acquisitions (sole-source, sole brand, State Use, etc.), and other acquisition matters. Considerations should include the need for forms for vendor notifications, bid analysis and summary, competitive invitations, instructions to bidders, policy statement of bid award, and sealed bid envelopes. Central Purchasing Unit personnel are responsible for obtaining bids on all material or services covered under this policy as described herein or the internal uniform procedures. Source selection methods shall be of the following types, depending upon the size and nature of the potential purchase:~~

~~(1) In accordance with the uniform procedures established by the Chief Financial Officer or designee, $5,000.00 or less.~~

~~(2) Written Over $5,000.00.~~

~~(3) Sealed Bids Over $50,000.00.~~

~~(4) Verbal/written follow-up on auxiliary boiler fuel, vehicle fuel and emergency confirmatory acquisitions in accordance with procedures established by the Chief Financial Officer or designee.~~

~~(c) The aforementioned thresholds are based on the estimated cost at the time of requisition made by the requisitioner. It is recognized that certain estimated costs may vary significantly with the bid amounts. If time is of the essence, or other appropriate justification is provided to obtain the goods or services, the estimated cost may govern the selection method. The Central Purchasing Unit may refer such instances to the General Manager. The General Manager or designee may require the requisitioner to justify that a good faith effort was made in developing the original cost estimate.~~

~~(d) If a dispute arises on purchased goods and services concerning vendor selection, quotation, or evaluation, the affected vendor may contact the Contracting and Acquisitions Agent assigned to the particular purchase for possible resolution of the dispute. If a dispute arises on purchased goods and services concerning the amount due or non-payment to a vendor, the affected vendor may contact the Accounts Payable Supervisor for possible resolution of the dispute. In both cases, should the dispute not be resolved to the vendor's satisfaction, the vendor may contact the GRDA employee designated by the Chief Financial Officer for further discussion.~~

~~(e) The Chief Financial Officer or designee will cause to be included in each bid request file a bid analysis summary, required certificates, and insurance requirement forms. The following factors to be considered in reviewing bids and awarding contracts may include, but are not necessarily limited to:~~

~~(1) Price~~

~~(2) Quality and conformance to specifications, affidavits and insurance requirements~~

~~(3) Bidder's previous record of performance and service~~

~~(4) Ability of bidder to render satisfactory service, delivery, etc.~~

~~(5) Free on Board points and shipping charges~~

~~(6) Last purchase cost~~

~~(7) Timeliness of delivery~~

~~(f) The right is reserved to reject any and all bids and to contract as the best interests of the Authority may require.~~

**300:20-1-12. Change orders**

All change orders shall be approved by the General Manager or designee, unless otherwise required by statute to be approved by the Board of Directors.

~~(a) A change order or cumulative change orders which are in excess of $50,000.00 shall require formal approval by the GRDA Board of Directors.~~

~~(b) A change order or cumulative change orders to a purchase order with an original value of $50,000.00 or less, which result in an amended purchase order in excess of $50,000.00, shall require formal approval by the GRDA Board of Directors.~~

~~(c) The GRDA Board of Directors must accept the additional adjusted amount of any change order subject to the above provisions prior to GRDA being responsible for payment thereof.~~

~~(d) Any change order not subject to the above provisions shall require written approval by the General Manager of GRDA prior to GRDA being responsible for payment thereof.~~

~~(e) All change orders shall be processed and approved in accordance with applicable statutory law.~~

**300:20-1-13. Emergency ~~confirmatory~~ purchase orders**

In the event the General Manager or designee determines that an emergency exists requiring ~~it becomes necessary to~~ purchase of an item or service or a series of related items or services, ~~in which the total amount exceeds $50,000.00, and prior to receiving formal Board approval authorizing such purchase, plus such purchase is mandatory to keep the facilities operating and, or~~ to ensure ~~continuous~~continued operation of transmission ~~service,~~and generation capabilities, or as otherwise defined in Rule 300:20-1-1(e)(6), and the total cost exceeds the dollar threshold delegated to the General Manager by the Board of Directors, the ~~general manager is authorized to~~General Manager may declare an emergency situation and immediately authorize the purchase of necessary materials or services. ~~Emergency~~Such emergency purchases ~~in this category will~~shall be presented to the GRDA Board for formal approval ~~as confirmatory purchase orders~~ at the next regularly scheduled Board meeting.

**300:20-1-14. Acquisition procedure**

The ~~Central Purchasing Unit~~Chief Financial Officer or designee shall, in conjunction with all other departments, promulgate, publish and maintain uniform procedures for the implementation of this Policy.

**300:20-1-15. Business expenses**

(a) The Legislature has recognized that GRDA is a unique agency, whose mission requires the district to function in competition with private industry within the competitive power market.

(b) The Legislature has further recognized and stated that GRDA shall document its business expenses which are necessary to carry out the business of the district and that such expenses shall meet current State of Oklahoma and Internal Revenue Service guidelines for business expense deductibility.

(c) ~~The~~Upon approval by the Board of Directors, the General Manager of GRDA ~~shall~~may designate the individuals and the extent of their authority to expend monies for business expenses. Such business expenses may include, but are not limited to, the following:

(1) Meals for GRDA personnel, Directors, or State Officials, ~~vendors,~~when dining with customers~~,~~or prospective customers~~, and others when~~or otherwise conducting GRDA business;

(2) Memorials to ~~business associates~~individuals and entities whose activities have contributed to the mission of GRDA, not to exceed $100.00 in any one fiscal year;

(3) Marketing tools, ~~items,~~including clothes, hats, ~~etc.~~or other items which may bear the GRDA logo or State of Oklahoma emblem;

(4) ~~Trade Association Memberships~~Assessments from regulatory agencies, trade association memberships, or training for ~~GRDA,~~ GRDA personnel, GRDA Directors and GRDA customers;

(5) Lodging expenses for GRDA personnel, Directors, state officials, customers and prospective customers when conducting and in furtherance of GRDA business;

(6) Miscellaneous business expenses which meet current State of Oklahoma and Internal Revenue Service guidelines for business expense deductibility.

(d) Reimbursement for such business expenses ~~may be reimbursed in~~shall not exceed the amount of the expense incurred.

(e) ~~All such expenses will be approved by~~To the extent practicable, the General Manager or his designee shall authorize the expense prior to it being incurred. All such expenses shall be approved by the General Manager or his designee prior to reimbursement and a summary provided monthly to the Board of Directors.

(f) Each ~~individual expense~~and every request for reimbursement shall include a justification for the expense for which reimbursement is requested and be supported by ~~a receipt~~specific

receipts and/or ~~invoice~~invoices, or other appropriate documentation to support the expense incurred, which shall be maintained in accordance with Internal Revenue Service guidelines.

**300:20-1-16. Reverse auction bidding [REVOKED]**

~~(a) As an alternative to any applicable acquisition procedure, a reverse auction bidding procedure may be used by the Central Purchasing Unit to obtain bids for the purchase of goods or services of any type or kind when to do so is the best interest of GRDA. The reverse auction shall be a real-time bidding process in which multiple suppliers, anonymous to each other, submit bids electronically to provide goods or services. GRDA may contract with a third party to conduct reverse auctions on its behalf.~~

~~(b) Reverse auctions held by or for GRDA shall be subject to the following:~~

~~(1) GRDA shall have the authority to require vendors to register and prequalify prior to participating in a reverse auction. As part of this process, GRDA may require vendors to agree to any terms, conditions or other requirements.~~

~~(2) GRDA shall have the authority to determine the criteria that will be used as the basis for making awards.~~

~~(3) Reverse auctions shall be held at a previously announced time and internet location and for a previously announced fixed duration. Reverse auction bids shall be accepted until the bid closure unless GRDA determines it is in its best interest to extend the closing time. Bidders must be notified of the extension by public announcement at the internet location at least fifteen (15) minutes prior to the original closing time. A bid may be received after bid closure only due to a significant error or event that affected the electronic receipt of any reverse auction bid.~~

~~(4) All reverse auction bids shall be posted and updated electronically and on a real-time basis.~~

~~(5) All bids submitted electronically through the reverse auction bidding process are subject to the same public disclosure laws and requirements that govern other bids.~~

~~(c) The Central Purchasing Unit shall develop such procedures and guidelines as necessary to implement this policy.~~

**300:20-1-17. Advanced payments**

GRDA generally shall not make advanced payment unless such is reviewed by legal counsel or approved by the General Manager, or designee. This review and approval shall include guidance included in the OMES Procedures Manual, applicable laws, or experience with the applicable vendor.

*[OAR Docket #13-930; filed 5-24-13]*

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## TITLE 300. GRAND RIVER DAM AUTHORITY
## CHAPTER 35. LAKE RULES

*[OAR Docket #13-931]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 11. Permits for Wharves, Landings, Buoys, Breakwaters and Docking Facilities
300:35-11-11. [AMENDED]
Subchapter 13. Permits for Dikes, Excavations, Dredgings, Erosion Control Devices, Retaining Walls, and Shoreline Stabilization
300:35-13-6. [AMENDED]
Subchapter 17. Raw Water Permits
300:35-17-3. [REVOKED]
Subchapter 21. Administration of Rules and Hearings
300:35-21-4. [AMENDED]
300:35-21-8. [AMENDED]
**AUTHORITY:**
Grand River Dam Authority; 82 O.S. 2010, § 861A(B)(1); 82 O.S.Supp. 2012, § 863.2(B).
**DATES:**
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Failure of the Legislature to disapprove the rules resulted in approval on May 17, 2013
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N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
The amendments include reimbursement of storage costs for personal property after notification and hearing of rule violation(s). Language has been removed regarding incomplete private and commercial dock permits and dredging permits expiring on March 9, 2012 or earlier. 300:35-17-3. ("Irrigation billing") has been revoked and other general clarifications have been made.
**CONTACT PERSON:**
Ellen Caslavka Edwards, General Counsel, Grand River Dam Authority, P.O. Box 409, Vinita, OK 74301, (918) 256-0800.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

## SUBCHAPTER 11. PERMITS FOR WHARVES, LANDINGS, BUOYS, BREAKWATERS AND DOCKING FACILITIES

**300:35-11-11. Expiration of permit**

(a) The construction, modification, installation, and final GRDA approval of private docks, landings, anchorages, boat houses, breakwaters, buoys, rail-systems, tram-systems, and fences must be completed within two (2) years from the date the permission to construct or modify is issued by GRDA.

(b) The construction, modification, installation, and final GRDA approval of commercial docks, landings, anchorages, boat houses, breakwaters, buoys, rail-systems, tram-systems, and fences, walls must be completed within seven (7) years from the date the permission to construct or modify is issued by GRDA and, if applicable, the Federal Energy Regulatory Commission.

(c) Prior to the expiration of the permission to construct or modify, the GRDA Board of Directors may extend the time in which such structure must be completed.

(d) ~~Private or commercial dock permits which were issued on or before March 9, 2005 for the installation of commercial or private docks, which were not complete as of March 9, 2005, shall expire seven (7) years of the date of issuance or no later than March 9, 2012 whichever date is earliest.~~

~~(e)~~ If the permit expires, the permit is null and void.

## SUBCHAPTER 13. PERMITS FOR DIKES, EXCAVATIONS, DREDGINGS, EROSION CONTROL DEVICES, RETAINING WALLS, AND SHORELINE STABILIZATION

**300:35-13-6. Expiration of permit**

(a) Any permit issued pursuant to Subchapter 13 of these rules must be completed within two (2) years from the date the permit or modification approval is issued by GRDA.

(b) Prior to the expiration of the dredging permit, the GRDA Board of Directors may extend the time in which such dredging activities must be completed.

(c) ~~Dredging permits which were issued on or before March 9, 2005 which dredging activities were not complete as of March 9, 2005, shall expire seven (7) years of the date of issuance or no later than March 9, 2012 whichever date is earliest.~~

~~(d)~~ If the permit expires, the permit is null and void.

## SUBCHAPTER 17. RAW WATER PERMITS

**300:35-17-3. Irrigation billing [REVOKED]**

~~(a) Upon approval of the application for an irrigation permit, the permittee may begin irrigation.~~

~~(b) If the permittee has provided facilities for measuring the water taken and used, he shall report the amount of water used to GRDA not later than the first day of November of each calendar year.~~

~~(c) In the event the permittee and GRDA agree that the amount of water taken will be fixed and established by agreement between the permittee and GRDA, a determination of the amount of water used will be made not later than the first day of March of that calendar year.~~

~~(d) In the event the permittee has used more than one (1) acre foot of water during the calendar year, he shall pay for all water in excess of one (1) acre foot on the basis of the fees above set forth before the end of the calendar year.~~

~~(e) If the term of the permit is for more than one (1) year, then the permittee shall pay the required fees and charges on the first day of January for each calendar year covered by said permit.~~

## SUBCHAPTER 21. ADMINISTRATION OF RULES AND HEARINGS

**300:35-21-4. Hearing officer**

The General Manager, or his designee, shall preside at any hearing. The General Manager may contract with an individual that is not employed by GRDA to preside at any hearing. The functions of the hearing officer shall commence upon his/her designation and terminate upon the entry of a Final Order issued by the Board of Directors. The hearing officer shall have the duty to conduct a fair hearing, to take all necessary action to avoid delay, and to maintain order. The hearing officer's authority shall include, but not be limited to:

(1) Arrange and change the date, time and place of hearings ~~and prehearing conferences~~ and issue notice thereof;

(2) Hold conferences to settle, simplify or determine the issues in a hearing, or to consider other matters that may aid in the expeditious disposition of the hearing;

(3) Require parties to state their position in writing with respect to the various issues in the hearing and to exchange such statements with all other parties;

(4) Administer oaths and affirmations;

(5) Examine witnesses and direct witnesses to testify;

(6) Receive, rule on, admit, exclude or limit evidence;

(7) Rule on pending motions and procedural items.

**300:35-21-8. Noncompliance, violations and penalties**

Any person, firm or corporation that fails to comply with, or violates any Rule promulgated by GRDA shall, after notice and an opportunity for hearing as provided for herein, be required to reimburse GRDA for any direct cost and overhead incurred as a result of such failure to comply or violation. Such costs may include, but are not limited to, the costs associated with the repair, restoration and reclamation of the lands and waters of GRDA and any storage costs for the Respondent's personal property. Additionally, GRDA may cancel any permit or license which has been issued in connection with said

boat, structure or facility and may remove or cause it to be removed from GRDA's lands and waters.

*[OAR Docket #13-931; filed 5-24-13]*

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

*[OAR Docket #13-857]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-25.[AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care ~~Faciliies~~Facilities
317:30-5-122. [AMENDED]
**(Reference APA WF # 12-09)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1902 of the Social Security Act
**DATES:**
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Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-25. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities
317:30-5-122. [AMENDED]
**Gubernatorial approval:**
January 28, 2013
**Register publication:**
30 Ok Reg 371
**Docket number:**
13-171
**(Reference APA WF # 12-09)**
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Policy will be amended to allow 100% payment of Medicare Crossover deductibles and coinsurance at skilled nursing facilities. Current policy allows payment at the Medicaid rate, which was previously adjusted to 0%. The rationale behind current policy is based on a federal policy that allowed federal reimbursement/write-offs for bad debts. That federal policy is no longer in effect and has prompted the policy amendment request.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 3. GENERAL PROVIDER POLICIES

### PART 1. GENERAL SCOPE AND ADMINISTRATION

**317:30-3-25. Crossovers (coinsurance and deductible)**
(a) **Medicare Part B.** Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals.
(b) **Medicare Part A.** Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals.~~limited to the Medicaid allowable reimbursement for services in a skilled nursing facility.~~
(c) **Medicare Advantage Plans.** Payment is made for Medicare HMO co-payments. For services offered by Medicare Advantage Plans that revert to traditional Medicare type benefits, payment is made for coinsurance and deductibles according to subsection (a) and (b) in this section.

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 9. LONG TERM CARE FACILITIES

**317:30-5-122. Levels of care**
(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.
(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** ~~When total payments from all other payers are less than the Medicaid rate, payment~~Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for the Mentally Retarded.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet.

(B) Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request or is unable to follow two-step instructions.

(C) Learning. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

*[OAR Docket #13-857; filed 5-21-13]*

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

*[OAR Docket #13-837]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-27. [AMENDED]
**(Reference APA WF # 12-20)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Oklahoma Telemedicine Act of 1997; 42 CFR 410.78
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Rules for Telemedicine are being revised to include specific provider responsibilities to assure compliance with HIPAA guidelines. Current policy is silent to appropriate HIPAA compliant applications, guidelines, devices, and/or safeguards concerning telemedicine services. The proposed revisions include additional conditions that apply to services rendered via telemedicine, provider responsibilities, and additional network standards as they relate to assuring HIPAA compliance during telemedicine related transmissions.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 3. GENERAL PROVIDER POLICIES

### PART 1. GENERAL SCOPE AND ADMINISTRATION

**317:30-3-27. Telemedicine**

(a) **Applicability and scope.** The purpose of this Section is to implement telemedicine policy that improves access to health care services by enabling the provision of medical specialty care in rural areas to meet the needs of members and providers alike, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. SoonerCare views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing an objective through medical assessment or problems in member's understanding of telemedicine, hands-on-assessment and/or care must be provided for the member. Quality of health care must be maintained regardless of the mode of delivery. A telemedicine encounter must comply with the Health Information Portability and Accountability Act (HIPAA) and shall include an originating site, distant site, and certified or licensed attendant to present the member at the originating site to the rendering provider located at the distant site.

(b) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Certified or licensed health care professional"** means an individual who has successfully completed a prescribed program of study in any variety of health fields and who has obtained an Oklahoma state license or certificate indicating his or her competence to practice in that field.

(2) **"Distant site"** means the site where the specialty physician/practitioner providing the professional service is located at the time the service is provided via audio/video telecommunications.

(3) **"Interactive telecommunications"** means multimedia communications equipment that includes, at a minimum, audio/video equipment permitting two-way, real-time or near real-time service or consultation between the member and the practitioner.

(4) **"Originating site"** means the location of the SoonerCare member at the time the service is being performed by a contracted provider via audio/video telecommunications.

(5) **"Rural area"** means a county with a population of less than 50,000 people.

(6) **"Store and forward"** means the asynchronous transmission of medical information to be reviewed at a later time. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video "clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

(7) **"Telehealth"** means the use of telecommunication technologies for clinical care (telemedicine), patient teaching and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

(8) **"Telemedicine"** means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the real-time or near real-time and in the physical presence of the member.

(9) **"Telemedicine network"** means a network infrastructure, consisting of computer systems, software and communications equipment to support telemedicine services.

(c) **Coverage.** SoonerCare coverage for telemedicine technology is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, ~~mental health assessments and,~~behavioral health assessments, behavioral health service plan development, pharmacologic management~~.~~, and services for medically high risk pregnancies.

(1) An interactive telecommunications system is required as a condition of coverage.

(2) Coverage for telemedicine services is limited to members in rural areas or geographic areas where there is a lack of ~~medical/psychiatric/mentalhealth~~medical specialty, psychiatric or behavioral health expertise locally. The coverage of all telemedicine services is at the discretion of OHCA.

(3) Office and outpatient visits that are conducted via telemedicine are counted toward the applicable benefit limits for these services.

(4) Authorized originating sites are:

(A) The office of a physician or practitioner;
(B) A hospital;
(C) A school;
(D) An outpatient behavioral health clinic;
(E) A critical access hospital;
(F) A rural health clinic (RHC);
(G) A federally qualified health center (FQHC); or
(H) An Indian Health Service facility, a Tribal health facility or an Urban Indian clinic (I/T/U).

(5) Authorized distant site specialty providers, excluding professionals under supervision, are contracted:

(A) Physicians;
(B) Advanced Registered Nurse Practitioners;
(C) Physicians Assistants;
(D) Genetic Counselors;
(E) Licensed Behavioral Health Professionals;
(F) Dieticians; and
(G) I/T/U's with specialty service providers as listed in (A) through (F) above.

(d) **Non-covered services.** Non-covered services include, but are not limited to:

(1) Telephone conversation;
(2) Electronic mail message; ~~and~~
(3) Facsimile~~.~~;

(4) Unencrypted, non-HIPAA complaint Internet-based communications;
(5) Video cell phone interactions;
(6) Outpatient surgical services;
(7) Home Health services;
(8) Well child checkups, and preventive visits;
(9) Laboratory services;
(10) Audiologist services;
(11) Care coordination services; and
(12) Physical, speech, or occupational therapy services.

(e) **Store and forward technology.** SoonerCare covers store and forward technology for applications in which, under conventional health care delivery, the medical service does not require face-to-face contact between the member and the provider. Examples include teleradiology, telepathology, fetal monitor strips, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically. SoonerCare does not consider these services telemedicine as defined by OHCA and will not reimburse an originating site fee for these services.

(f) **Conditions.** The following conditions apply to all services rendered via telemedicine.

(1) Interactive audio and video telecommunications must be used, permitting encrypted real-time communication between the distant site physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telemedicine information transmitted. As a condition of payment the member must be physically present at the originating site and ~~participating~~must participate in the telemedicine visit. The originating site must provide pertinent medical information and/or records to the distant site provider via a secure HIPAA compliant transmission.

(2) Only telemedicine services provided utilizing an OHCA approved network are eligible for reimbursement.

(3) For SoonerCare reimbursement, telemedicine connections to rural areas must be located within Oklahoma and the health providers must be licensed in Oklahoma or practice at an I/T/U.

(4) The telemedicine equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent in its operation.

(5) The medical or behavioral health related service must be provided by a distant site provider that is located at an approved HIPAA compliant site, or site in compliance with HIPAA Security Standards. A telemedicine approved site is one that has the proper security measures in place, the appropriate administrative, physical and technical safeguards should be in place that ensure the confidentiality, integrity, and security of electronic protected health information. The physical environments at both the originating and distant site are clinical environments and the spaces should reflect that. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, placement and selection of the rooms should consider this. An appropriate certified or licensed health care professional at the originating site is required to present the member to the physician or practitioner at the distant site and remain available as clinically appropriate.

(6) The health care practitioner must obtain written consent from the SoonerCare member that states they agree to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.

(7) If the member is a minor child, a parent/guardian must present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

(8) The member retains the right to withdraw at any time.

(9) ~~All existing confidentiality protections apply.~~All telemedicine activities must comply with the HIPAA Security Standards, OHCA policy, and all other applicable state and federal laws and regulations.

(10) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

(11) There will be no dissemination of any member images or information to other entities without written consent from the member.

(g) **Reimbursement.**

(1) A facility fee will be paid to the originating site when the appropriate telemedicine facility fee code is used.

(A) Hospital outpatient: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the SoonerCare fee schedule.

(B) Hospital inpatient: For hospital inpatients, payment for the originating site facility fee will be paid outside the Diagnostic Related Group (DRG) payment.

(C) FQHCs and RHCs: The originating site facility fee for telemedicine services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee is paid separately from the center or clinic all-inclusive rate.

(D) Facilities of the Indian Health Service, tribal facilities or Urban Indian Clinics: When an I/T/U serves as the originating site, the originating site facility fee is reimbursed outside the OMB rate.

(E) Physicians'/practitioners' offices: When the originating site is a physician's office, the originating site facility fee will be paid according to the SoonerCare fee schedule. If a provider from the originating

site performs a separately identifiable service for the member on the same day as telemedicine, documentation for both services must be clearly and separately identified in the member's medical record.

(2) Services provided by telemedicine must be billed with the appropriate modifier. Only the portion of the telemedicine service rendered from the distant site is billed with the modifier. Coding and billing the appropriate modifier with a covered telemedicine procedure code, the distant site provider and/or practitioner certifies that the member was present at the originating site when the telemedicine service was furnished.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed at the originating site during a telemedicine transmission, the technical component and a telemedicine facility fee are billed by the originating site. The professional component of the procedure and the appropriate visit code are billed by the distant site.

(4) Reimbursement for telemedicine services is available only when the originating site is located in a geographic area where there is a lack of medical/psychiatric/behavioral health expertise and the distance from the originating and distant site is greater than 20 miles apart, with few exceptions. The OHCA may make an exception to this requirement based on geographic limitations and service constraints. The OHCA has discretion and the final authority to approve or deny any telemedicine services based on agency and/or SoonerCare members' needs. Services are not reimbursable when provided primarily for the convenience of the provider. Adequate documentation must be maintained as service is subject to post payment review. Post payment review may result in adjustments to payment when a telemedicine modifier is billed inappropriately or not billed when appropriate.

(5) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

(h) **Documentation.**

(1) Documentation must be maintained at the originating and the distant locations to substantiate the services provided.

(2) Documentation must indicate the services were rendered via telemedicine, the location of the originating and distant sites, and which OHCA approved network was used.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(i) **Telemedicine network standards.** In order to be an approved telemedicine network, an applicant must be contracted with the OHCA and meet certain technical and privacy standards stated within the contract in order to ensure the highest quality of care. Contracted networks must complete HIPAA Security Risk and Mobile Device Analysis associated with remote access to, and offsite use of, Electronic Protected Health Information (ePHI). Networks must develop and implement risk management measures to assure the safeguard of ePHI. The OHCA has discretion and the final authority to approve or deny any telemedicine network based on agency and/or SoonerCare members' needs.

(j) **Telemedicine provider responsibilities.** Providers must adhere to privacy standards for the confidentiality, integrity, and security of ePHI. Privacy standards include but are not limited to the following:

(1) Complying with Health Insurance Portability and Accountability Act (HIPAA) and security protection for the member in connection with the telemedicine communication and related records.

(2) Submitting a Mobile Device Security Assessment to the OHCA Provider Enrollment Unit, to assure that SoonerCare members' ePHI will not be compromised. Providers are required to attest to compliance with applicable provisions of HIPAA and submit one of the following:

(A) A completed OHCA Provider HIPAA Mobile Device Security Assessment form; or

(B) A copy of the provider's most recent HIPAA Security Assessment, mobile device section only, with any risk compromising wording redacted.

(3) Obtaining and maintaining technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA, and OHCA Provider and Network Contracts.

(4) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records to unauthorized persons.

(5) Maintaining clinical documentation.

*[OAR Docket #13-837; filed 5-21-13]*

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

*[OAR Docket #13-842]*

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**ANALYSIS:**
Policy on the Oklahoma Electronic Health Records Incentive Program will be updated to account for changes in federal rules on the program. Changes include adding additional options for patient volume calculation, expanding the definition of a Children's Hospital, adding an exception to the hospital-based eligible professional criteria, and allowing CMS to take over administrative appeals for cases in which they are they auditor on meaningful use provisions.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. GENERAL PROVIDER POLICIES

## PART 1. GENERAL SCOPE AND ADMINISTRATION

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

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

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

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

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

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

(2) **Eligible hospitals.** Eligible hospitals are Children's Hospitals or Acute Care Hospitals, including Critical Access Hospitals and cancer hospitals. An Acute Care Hospital is defined as a health care facility where the average length of patient stay is twenty-five (25) days or fewer and that has a CMS certification number that has the last four digits in the series 0001-0879 and 1300-1399. A Children's Hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under 21 years of age and has a CMS certification number with the last 4 digits in the series 3300-3399 or, if it does not have a CMS certification number, has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR incentive program. Hospitals that do not meet either of the preceding definitions are not eligible for incentive payments.

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

(1) **Eligible professionals.** Eligible professionals must meet a 30% SoonerCare patient volume threshold over a continuous 90-day period in the preceding calendar year or the preceding 12 month period from the date of attestation. The only exception is for pediatricians, as discussed in OAC 317:30-3-28(c)(5).

(2) **Eligible hospitals.** With the exception of children's hospitals, which have no patient volume requirement, eligible hospitals must meet a 10% SoonerCare patient

volume threshold over a continuous 90-day period in the preceding calendar year or over the most recent continuous 12 month period for which data are available prior to the payment year.

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

(A) Received medical assistance from SoonerCare;

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

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

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

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

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

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

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

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

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

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

(d) **Attestation.** Eligible professionals and eligible hospitals must execute an amendment to their SoonerCare Provider Agreement to attest to meeting program criteria through the Electronic Provider Enrollment (EPE) system in order to qualify for incentive payments. Registration in the CMS EHR Incentive Payment Registration and Attestation system is a pre-requisite to EPE attestation.

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

(f) **Meaningful use.** Eligible professionals in their second through sixth participation year and eligible hospitals in their second through third participation year must attest to meaningful use of certified EHR technology. Eligible hospitals must attest to meaningful use if they are participating in both the Medicare and Oklahoma EHR Incentive Programs in their first participation year. The definition of "meaningful use" is outlined in, and determined by, the Electronic Health Records Program Final Rule CMS-0033-F.

(g) **Payment.** Eligible professionals may receive a maximum of $63,750 in incentive payments over six years. Providers must begin their participation by 2016 to be eligible for payments. Payments will be made one time per year per provider and will be available through 2021. Eligible hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016.

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

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

(h) **Administrative appeals.** Administrative appeals of decisions related to the Oklahoma Electronic Health Records Incentive Program will be handled under the procedures described in OAC 317:2-1-2(b). The only exception to this section is when CMS conducts meaningful use audits. Results of any adverse CMS audits are subject to the CMS administrative appeals process and not the state appeal process.

*[OAR Docket #13-842; filed 5-21-13]*

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

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Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-64. [NEW]
Subchapter 5. Individual Providers and Specialties

Part 32. SoonerRide Non-Emergency Transportation
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317:30-5-328. [REVOKED]
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**ANALYSIS:**
SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, and eligibility. Proposed revisions will move meals and lodging policy to "General Medical Program Information" for clarification purposes. Additional revisions include updating outdated reference to the code of federal regulation concerning non-emergency transportation. Proposed revisions will define lodging for clarification purposes, and include eligibility requirements for escorts if SoonerCare member is removed from his/her home and appointed a temporary guardian.

**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. GENERAL PROVIDER POLICIES

## PART 3. GENERAL MEDICAL PROGRAM INFORMATION

**317:30-3-64. Payment for lodging and meals**

(a) Payment for lodging and/or meals assistance for an eligible member and/or an approved medical escort is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and/or medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(1) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to 24 hours prior to the start of member's medical services and up to 24 hours after the services end. Lodging is approved for the member and/or one approved medical escort. The following factors may be considered by the OHCA when approving reimbursement for a member and/or one medical escort:

(A) travel is to obtain specialty care; and

(B) the trip cannot be completed during SoonerRide operating hours; and/or

(C) the trip is 100 miles or more from the member's residence, as listed in the OHCA system, to the medical facility; and/or

(D) the member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.

(2) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(3) Meals will be reimbursed only if lodging criteria is met.

(4) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(5) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to 14 days without prior approval; stays exceeding the 14 day period must be prior approved. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.

(6) For eligible members in the Neonatal Intensive Care Unit (NICU) a minimum visitation of 6 hours per day for the approved medical escort is required for reimbursement of lodging and/or meals services.

(b) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be approved. If lodging and/or meals assistance with contracted Room and Board providers are not available, the member and/or medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the lodging criteria have been met. Reimbursement must not exceed state per diem amounts. The OHCA has

discretion and the final authority to approve or deny lodging and/or meals reimbursement.

(c) Payment for transportation and lodging and/or meals of one medical escort may be approved if the service is required.

(d) If the Oklahoma Department of Human Services (OKDHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for medical escort related lodging and/or meals services. The custodial parent, if under investigation, is not eligible. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(1) when the individual's health or disability does not permit traveling alone; and

(2) when the individual seeking medical services is a minor child.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

### 317:30-5-327. Eligibility for SoonerRide NET

Transportation is provided when medically necessary in connection with examination and treatment to the nearest appropriate facility in accordance with ~~42 CFR 441.170.~~42 CFR 440.170. As the Medicaid Agency, ~~OHCA~~the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Individuals considered fully dual eligible qualify for SoonerRide. However, SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries(QMB);

(2) Specified Low Income Medicare Beneficiaries (SLMB);

(3) Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD);

(4) inpatient;

(5) institutionalized(i.e. long-term care facility);

(6) Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children, the Advantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

### 317:30-5-328. Subsistence (sleeping accommodations and meals) [REVOKED]

~~(a) Lodging and meals assistance for eligible members is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking reimbursement for lodging.~~

~~(1) Lodging and/or meals are reimbursable when prior authorized. The following factors may be considered by OHCA when authorizing reimbursement:~~

~~(A) travel is to obtain specialty care; and~~

~~(B) the trip cannot be completed during SoonerRide operating hours;~~

~~(C) the trip is more than 100 miles from the member's city of residence; or~~

~~(D) the treatment requires an overnight stay.~~

~~(2) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.~~

~~(3) Meals will be reimbursed only if an overnight stay occurs and the stay meets the lodging criteria.~~

~~(4) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.~~

~~(5) During inpatient or outpatient medical stays, meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.~~

~~(b) A member who needs lodging and/or meals assistance must first seek services with a contracted lodging provider. If the lodging provider provides meals the member may not be reimbursed for services billable by the contracted lodging provider. If lodging and/or meals assistance with contracted lodging providers are not available, the member may request reimbursement assistance by submitting a travel reimbursement form. The travel reimbursement form may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement form must be documented with receipts, and reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny meals and lodging reimbursement.~~

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

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317:30-3-71. [REVOKED]
317:30-3-75. [REVOKED]
317:30-3-77. [REVOKED]
317:30-3-81. [REVOKED]
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**ANALYSIS:**
Obsolete eligibility rules included in the Provider Manual (Chapter 30) are revoked. All topics covered in the obsolete sections are already covered in Chapter 35 of agency rules.

**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. GENERAL PROVIDER POLICIES

## PART 5. ELIGIBILITY

### 317:30-3-70. Categorical relationship [REVOKED]

~~(a) To be eligible for Medicaid benefits, an individual must be related to one of the following programs:~~

~~(1) Aid to the Aged~~
~~(2) Aid to the Disabled~~
~~(3) Aid to the Blind~~
~~(4) Pregnancy-Related Services~~
~~(5) Aid to Families With Dependent Children~~

~~(b) Categorical relationship for (a)(1) through (a)(3) above is established using the same criteria and definitions of age, disability and blindness as are used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is an aged, blind, or disabled SSA/SSI recipient in current payment status (including presumptive eligibility), or a TANF recipient, categorical relationship is already established.~~

~~(c) Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and post-partum periods.~~

~~(d) Categorical relationship to AFDC is established by determining deprivation due to absence, death or incapacity the same as for the TANF money payment.~~

~~(e) It is the responsibility of the OHCA Level of Care Evaluation Unit (LOCEU) to determine categorical relationship to incapacity or disability for an individual when appropriate. It is the responsibility of DHS to provide the necessary information to the LOCEU in order to make these determinations.~~

~~(f) Once categorical relationship has been determined, financial need must be established.~~

### 317:30-3-71. Financial need [REVOKED]

~~**Categorically needy.**An individual is categorically needy if income and resources are at or below the category of assistance to which he/she is related, i.e., Aid to the Aged, Aid to the Blind, Aid to the Disabled or Aid to Families with Dependent Children, during the month of medical service. These persons are issued a permanent plastic identification card.~~

### 317:30-3-75. Person codes [REVOKED]

~~Person codes are assigned to individuals as they are added to a case. An individual's person code may be 01, 02, 03, or 04, etc., without regard to sex or status as adult or child. If a medical card is not available to determine the proper person code, contact should be made with the local county Department of Human Services office.~~

### 317:30-3-77. Notification of needed medical services [REVOKED]

~~(a) When an individual not currently eligible, including Medicare eligible individuals, requests the physician and/or hospital to bill the Authority for medical services, Form MS-MA-5, Notification of Needed Medical Services, may be completed by the physician and a designated representative of the facility which is to provide the medical services or the patient, parent or guardian may make application by completing an Application for Medical Services. The original forms are routed to the Oklahoma Department of Human Services office in the county of the patient's residence for determination of eligibility. The date of the application is the date the first form received is stamped into the local OKDHS county office. If the patient is in the hospital, application should be made while the patient is still in the hospital, if at all possible.~~

~~(b) For pregnant women requesting medical services, Form MS-MA-5 is not required, but will be accepted as medical verification of pregnancy. If Form MS-MA-5 is not completed, a letter or written statement from the physician or certified nurse midwife is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant. The expected date of delivery must also be established. This can be established from either medical information from the physician or nurse midwife or, in absence of these reports, the applicant's statement.~~

**317:30-3-81. Notification of eligibility status for assistance (adults) [REVOKED]**

~~For those individuals not receiving a State Supplemental Payment, but determined eligible for medical services, notification of eligibility for payment of services will be by MS-MA-4, Notification of Eligibility Status for Medical Assistance, issued by the local County DHS office or a computer generated notice.~~

**317:30-3-85. Citizenship and alienage [REVOKED]**

~~In order to be eligible for payment of the full range of medical services through SoonerCare, an individual must be either a citizen of the United States or an alien lawfully admitted for permanent residence for a period greater than five years from the date of entry or otherwise permanently residing in the United States under color of law. Legalized aliens may receive emergency medical services and pregnancy-related services. Illegal aliens may receive only emergency medical services, which includes emergency labor and delivery. Refer to OAC 317:35-5-25 regarding citizenship/alien status and identity verification requirements.~~

**317:30-3-86. Residency [REVOKED]**

~~An individual must be a resident of Oklahoma although no durational requirement is imposed.~~

**317:30-3-87. Presumptive eligibility [REVOKED]**

~~(a) Pregnant women may be eligible for certification under the Authority's presumptive eligibility program. The presumptive eligibility program provides for immediate certification of pregnant women while a formal application is being processed. Therefore, enabling the client to receive needed ambulatory services. Providers who will be able to make presumptive eligibility determinations will be required to meet all of the following criteria.~~

~~(1) Qualified presumptive eligibility providers must be eligible for payment under the Authority's Medicaid Program.~~

~~(2) They must provide services of the type provided by outpatient hospitals, rural clinics or those clinics furnished by, or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.~~

~~(3) They have been specifically designated in writing by the Authority as a qualified Presumptive Eligibility provider which the Authority has determined they are capable of making presumptive eligibility determinations.~~

~~(4) They must meet one of the following:~~

~~(A) Receive funds under one of the following~~

~~(i) The Migrant Health Centers, Community Health Centers or Public Health Service primary care research and demonstration projects,~~

~~(ii) The Maternal and Child Health Services Block Grant Programs, or~~

~~(iii) Title V of the Indian Health Care Improvement Act; or~~

~~(B) They must be participants in a program established under the Special Supplemental Food Program for Women, Infants and Children (WIC) or the Commodity Supplemental Food Program; or~~

~~(C) They must be participants in a State perinatal program; or~~

~~(D) They are an Indian Health Service program or facility operated by a tribe or tribal organization under the Indian Self Determination Act.~~

~~(b) Providers interested in being certified as a Presumptive Eligibility Provider should submit evidence of meeting the above requirements to the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.~~

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

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**(Reference APA WF # 12-08)**
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Policy will be amended to define the circumstances under which genetic testing will be covered by OHCA. Both the volume and cost of genetic testing are growing, and the growth rates are expected to rise significantly going forward. Currently, OHCA has no written policy addressing the medical necessity of genetic testing, although claims are being paid through nonspecific laboratory codes. Policy will set medical necessity criteria similar to other states' Medicaid programs and private insurance, which requires the member to undergo a genetic risk assessment or display clinical evidence indicating a chance of a genetic abnormality AND that those results change treatment, change health monitoring, provide prognosis, or provide information needed for genetic counseling for the patient.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## 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) SoonerCare program, 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 surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(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 member, 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 administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, 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 execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices 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.

(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.

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

(S) 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.

(T) 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.

(U) 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 signs off on the billed encounter;

(ii) Attending physician is 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.

(V) 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.

(W) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

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

(Y) 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.

(Z) 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.

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) 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 beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma 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.

(EE) 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, advanced registered nurse practitioners, certified 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 care coordination 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.

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

(GG) Genetic testing is covered when medically necessary. Genetic testing is considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) The result of the test will directly impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is considered scientifically valid for the identification of a specific genetically-linked inheritable disease; and

(iv) Documentation is provided from a licensed genetic counselor or physician with genetic expertise that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for 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 on the same day, except when supplemental skills are required and different specialties are involved.

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(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 hysterectomies.

(I) Medical services considered 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 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 review or multidisciplinary opinion, dictation, and similar functions.

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

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

(P) 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.)

(Q) Speech and Hearing services.

(R) Mileage.

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

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

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) 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 SoonerCare program, 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. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state

or federal exception to this requirement. 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 SoonerCare compensable.

(A) 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 are not 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 is 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. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

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

(A) Inpatient admission for 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 on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

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

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

(G) Non-therapeutic hysterectomies.

(H) Medical Services considered 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 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 review or multidisciplinary opinion, dictation, and similar functions.

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

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

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

(O) Mileage.

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

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. 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 or within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

*[OAR Docket #13-845; filed 5-21-13]*

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

*[OAR Docket #13-847]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-14. [AMENDED]
**(Reference APA WF # 12-35)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; CMS-2370-F, 42 CFR 438, 441, and 447; Sections 1902(a)(13), 1902(jj), 1932(f), and 1905(dd) of the Social Security Act
**DATES:**
**Comment period:**
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April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
**Final adoption:**
May 14, 2013
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July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Agency policy is amended to allow for reimbursement of a separately payable administration fee for vaccines given to adults. Further, the policy clarifies Vaccine for Children Program administration fee rules.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 1. PHYSICIANS

**317:30-5-14. Injections**

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for SoonerCare. SoonerCare payment is not available for injectable drugs whose manufacturers have not entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS). OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) subject to the exclusions and limitations provided in OAC 317:30-5-72.1.

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. For vaccines administered as part of the Vaccines for Children Program, only one administration fee is permitted per vaccine, regardless of the number of vaccine/toxoid components in the vaccine.~~When the vaccine is not included in the program, the administration fee is included in the vaccine payment.~~ Payment will not be made for vaccines covered by the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is separately payable.

(2) **Immunizations for adults.** Coverage for adults is provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines. A separate payment will ~~not~~ be made for the administration of a vaccine.~~unless specifically outlined in policy. The administration fee is included in the vaccine payment.~~Only one administration fee per vaccine is permitted, regardless of the number of vaccine/toxoid components in the vaccine.

(b) Providers must use the appropriate HCPCS code and National Drug Code (NDC). In addition to the NDC and HCPCS code, claims must contain the drug name, strength, and dosage amount.

(c) Payment is made for allergy injections for adults and children. When the contracted provider actually administers or supervises the administration of the injection, the administration fee is compensable. No payment is made for administration when the allergy antigen is self-administered by the member. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim.

(d) Rabies vaccine, Imovax, Human Diploid and Hyperab, Rabies Immune Globulin are covered under the vendor drug program and may be covered as one of the covered prescriptions per month. Payment can be made separately to the physician for administration. If the vaccine is purchased by the physician, payment is made by invoice attached to the claim.

(e) Human Papillomavirus (HPV) vaccine is approved and covered under guidelines established by the ACIP for children and adults. Payment can be made separately to the physician for administration and the vaccine product.

(f) Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.

(g) If a physician bills separately for surgical injections and identifies the drugs used in a joint injection, payment will be made for the cost of the drug in addition to the surgical injection. The same guidelines apply to aspirations.

(h) When IV administration in a Nursing Facility is filed by a physician, payment may be made for medication. Administration should be done by nursing home personnel.

(i) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit reimbursement.

(j) In the event a pandemic virus is declared by the Centers for Disease Control (CDC) and/or the Department of Health & Human Services, an administration fee will be paid to providers for administering the pandemic virus vaccine to adults and children as authorized by the Centers for Medicare and Medicaid Services (CMS).

*[OAR Docket #13-847; filed 5-21-13]*

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

*[OAR Docket #13-848]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-58.[AMENDED]
**(Reference APA WF # 12-33)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 1381/42 CFR 447.272 and 447.321
**DATES:**
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March 14, 2013
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March 14, 2013
**Gubernatorial approval:**
April 29, 2013
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**Final adoption:**
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
SHOPP rules are revised to clarify overpayment and recoupment procedures, if it is determined due to appeal, penalty, or other reason that additional allocation/ recoupment fund is necessary.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 3. HOSPITALS

**317:30-5-58. Supplemental Hospital Offset Payment Program.**

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services~~. In~~in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes.

(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority

(OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) **"Fee"** means supplemental hospital offset assessment pursuant to Section 3241.1 of Title 63 of the Oklahoma Statutes.

(3) **"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to Section 1-701.1 of Title 63 of the Oklahoma Statutes maintained primarily for the diagnosis, treatment, or care of patients~~;~~.

(4) **"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

(5) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines ~~16, 17 and 18)~~"Total inpatient routine care services", Ancillary services", "Outpatient services") of the Medicare Cost Report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)"Net patient revenues") and Worksheet G-2 (Part I, Column 3, Line ~~25~~"Total patient revenues")~~;~~.

(6) **"Medicare Cost Report"** means ~~form CMS-2552-96,~~ the Hospital Cost Report, ~~as it existed on January 1, 2010;~~ Form CMS-2552-96 or subsequent versions.

(7) **"Upper payment limit"** means the maximum ceiling imposed by 42 C F R §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government~~; and~~.

(8) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 Okla. Stat. §§ 3241.1 through 3241.6 the Oklahoma Health Care Authority (OHCA) ~~was~~is mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) a hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicaid and State operations.

(B) a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C)a hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, ~~Using~~using substantially equivalent data provided by the hospital:

(i) treatment of a neurological injury;

(ii) treatment of cancer;

(iii) treatment of cardiovascular disease;

(iv) obstetrical or childbirth services; or

(v) surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) a hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTermCareHospitalPPS/08down load.asp or as a children's hospital; and

(E) a hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at http://www.flexmonitoring.org/cahlistRA.cgi, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The Supplemental Hospital Offset Payment Program Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).

(2) OHCA will review and determine the amount of annual assessment in December of each year.

(3) A hospital may not charge any patient for any portion of the SHOPP assessment.

(4) The Method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)

(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 5% of the amount and interest of 1.25% per month. ~~The SHOPP assessment must be received by OHCA no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday Sunday), the assessment is due by 5 p.m. (Central Standard Time) of the following business day (Monday Friday).~~

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:

(i) a penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(ii) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) the quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in future payments~~. In~~in accordance with OAC 317:2-1-15 SHOPP appeals.

(iv) If additional allocation or recoupment resulting from an appeal is for the current calendar year and another SHOPP payment is scheduled for the calendar year, an adjustment to the next payment will be calculated. If additional allocation or recoupment is for a prior calendar year, a separate payment/account receivable (AR) will be issued.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) **Supplemental Hospital Offset Payment Program Cost Reports.**

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, ~~"Whoever~~"Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's ~~fiscal year 2009~~applicable Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS) file.

(A) Through 2013, the base year for assessment shall be the hospital's fiscal year that ended in 2009, as contained in the HCRIS file dated December 31, 2010;

(B) For years 2014 and 2015, the base year for assessment shall be the hospital's fiscal year that ended in 2012, as contained in the HCRIS file dated June 30, 2013; and

(C) For subsequent two-year periods the base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g.,2016 & 2017 - 2014 fiscal year; 2018 & 2019 - 2016 fiscal year), as contained in the HCRIS file dated June 30 of the following year.

(5) If a hospital's ~~fiscal year 2009~~applicable Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services'~~Healthcare Cost Report Information System~~ HCRIS file ~~dated December 31,2010~~, the hospital will submit a copy of the hospital's ~~2009~~ applicable Medicare Cost Report to the Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a ~~2009~~ Medicare Cost Report, the hospital will submit its initial Medicare Cost Report to Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year

using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **Closure, merger and new hospitals.**

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within 30 days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by ~~November 1,2011 for the 2012 assessment, and for subsequent years' assessment calculation by~~ September 30 of ~~the preceding~~each year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital~~; not to~~and cannot exceed the UPL for the class.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital~~; not to~~and cannot exceed the UPL for the class.

(3) Medicaid payments to a group of facilities within approved categories may not exceed the upper payment limit in accordance with 42 CFR 447.272 (b) (2) and 42 CFR 447.321 (b) (2). If any ~~retrospective~~ audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed~~.If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.~~based on the following methods:

(A) If it is determined prior to issuance of hospital access payments that the pool of hospitals would exceed the upper payment limit estimate of that pool, the amount above the UPL estimate will be allocated to another pool of hospitals that does not exceed the upper payment limit estimate of that pool. The reallocation can be applied to multiple pools if necessary.

(B) If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

(4) In order to ensure sufficient funds to make payments effective July 1, 2013 OHCA shall reduce the next quarterly payment by 1.4% (OHCA will pay out 23.6% of the assessment rather than 25%). This reduction will be distributed in the fourth quarter of the year as soon as all assessments are received. This payment will also be increased by penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the 4th quarterly payment being processed the 4th quarter may be adjusted to pay out 26.4% plus accrued penalties.

(5) Effective for all subsequent calendar years the OHCA will distribute payments in the following quarterly percentages: 23.6%, 25%, 25%, 25%. A 5th payment of 1.4% in the fourth quarter of each calendar year will also be made as soon as all assessments are received. This payment will also be increased by any penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the 4th quarterly payment being processed the 4th quarter payment may be adjusted to pay out 26.4% plus accrued penalties.

*[OAR Docket #13-848; filed 5-21-13]*

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

*[OAR Docket #13-846]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 18. Genetic Counselors
317:30-5-221. [AMENDED]
317:30-5-223. [AMENDED]
**(Reference APA WF # 12-37)**
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Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes
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**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Policy is amended to expand genetic counseling services to all members that are eligible for medically necessary genetic testing. Currently, we only cover genetic counseling for members with a pregnancy at high risk of genetic abnormalities.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 18. GENETIC COUNSELORS

**317:30-5-221. Coverage**

(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in 317:30-5-2(a)(1)(GG) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes 60 days postpartum. Reasons for genetic counseling include but are not limited to the following:

(1) advanced maternal age;
(2) abnormal maternal serum first or second screening;
(3) previous child or current fetus/infant with an abnormality;
(4) consanguinity/incest;
(5) parent is a known carrier or has a family history of a genetic condition;
(6) parent was exposed to a known or suspected reproductive hazard;
(7) previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
(8) history of recurrent pregnancy loss; or
(9) parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

**317:30-5-223. Documentation**

All services must be documented in the member's medical record. All ~~prenatal and postpartum~~ genetic counseling sessions must, at a minimum, include the following:

(1) date of service;
(2) start and stop time for each treatment session;
(3) practitioner's signature;
(4) pedigree, and/or review and interpretation of family history; and
(5) recommendation and plan of care.

*[OAR Docket #13-846; filed 5-21-13]*

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

*[OAR Docket #13-856]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 19. Nurse Midwives
317:30-5-225.[AMENDED]
317:30-5-226.[AMENDED]
317:30-5-229. [NEW]
Part 87. Birthing Centers
317:30-5-890.[AMENDED]
317:30-5-890.1.[NEW]
317:30-5-891.[AMENDED]

**(Reference APA WF # 12-14)**
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**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Rules for Nurse Midwifes and Birthing Center services are being revised to align with current obstetric policy. Proposed changes include clarification concerning the type of nurse midwife approved to provide SoonerCare coverage, and the coverage the nurse midwife can provide to eligible members. Additionally, proposed revisions include clean-up to remove language that references outdated practices concerning enrollment, and format changes for consistency and clarity purposes.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 19. CERTIFIED NURSE MIDWIVES

### 317:30-5-225. Eligible providers

The Certified Nurse-Midwife must be a qualified professional nurse registered with the Oklahoma Board of Nurse Registration and Nursing Education who possesses evidence of certification according to the requirement of the American College of Nurse-Midwives, and has the right to use the title Certified Nurse-Midwife and the abbreviation C.N.M. Nurse Midwives who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. The certified nurse midwife accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice nursing standards and functions as defined by the scope of practice/role definition statements for the certified nurse midwife. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

~~(1) In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.~~

~~(2) The signature of the Nurse Midwife on Form MS-MA-5, Notification of Needed Medical Services, will be acceptable as medical verification of pregnancy. Form MS-MA-5 should be filed after the first prenatal visit with the local county Oklahoma Department of Human Services office in the county where the patient resides. If Form MS-MA-5 is not completed, a written statement from the Nurse Midwife verifying the applicant is pregnant and the expected date of delivery is acceptable.~~

### 317:30-5-226. Coverage by category

(a) **Adults.** Payment is made for certified nurse midwife services ~~including management of normal care of the mother and newborn(s) throughout the maternity cycle~~within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life.

(1) ~~The county OKDHS office where the mother resides must be notified in writing within five days of the child's birth in order for an individual person code to be assigned to the newborn.~~Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

~~(3) Providers must use OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.~~

(~~4~~3) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care~~, and any ultrasounds performed by the attending provider~~. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b). For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(b) ~~**Children.**~~ **Newborn.** Payment to nurse midwives for services to ~~children~~newborn is the same as for adults. A newborn is an infant during the first 28 days following birth.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

**317:30-5-229. Reimbursement**

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(1) Medical verification of pregnancy is required. A letter or written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.

(2) Newborn charges billed on the mother's person code will be denied.

(3) Providers must use OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.

(4) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

## PART 87. BIRTHING CENTERS

**317:30-5-890. ~~Birthing Center Services~~Eligible providers**

~~(a) **Definition of birthing centers.** A birthing center means a facility, place or institution which is maintained or established primarily for the purpose of providing services of a certified midwife or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy.~~

~~(b) **Eligible providers.**~~ Eligible providers are birthing centers ~~which have been~~that are currently licensed by the Oklahoma State Health Department and meet the requirements listed in (1) - (4) of this subsection:

(1) Have a current written agreement with a board certified OB/GYN to provide coverage for consultation, collaboration or referral services as defined by the American College of Nurse-Midwives.

(2) Have a current medical director who is a board certified OB/GYN and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual patient coverage for consultation, collaborative or referral service.

(3) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24 hour availability of OB/GYN and capability of performing a C-section within 30 minutes~~.~~of the decision to operate. The 30 minute timeframe is subject to each hospital's unique circumstance, logistical issues that include, but are not limited to, obtaining informed consent, transporting the patient, and any other potential problems that may arise.

(4) Must be accredited by the Commission for the Accreditation of Freestanding Birth Centers.

**317:30-5-890.1. Definitions**

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

**"Birthing center"** means a freestanding facility, place or institution, which is maintained or established primarily for the purpose of providing services of a certified midwife or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy.

**"Certified Nurse Midwife"** means a person educated in the discipline of nursing and midwifery, certified by the American College of Nurse-Midwives (ACNM) and licensed by the state to engage in the practice of midwifery and as a registered nurse.

**"Low-risk"** means a normal, uncomplicated prenatal course as determined by adequate prenatal care and prospects for a normal, uncomplicated birth as defined by generally accepted criteria of maternal and fetal health.

**"Newborn"** means an infant during the first 28 days following birth.

**317:30-5-891. Coverage by category**

(a) **Adults.** Payment is made for birthing center services for adults and includes admission to the birthing center of low-risk, uncomplicated pregnancies, with an anticipated spontaneous vaginal delivery for the period of labor and delivery.

(b) ~~**Children.**~~ **Newborn.** Coverage for ~~persons under age 21 is the same as adults.~~newborns within scope of practice as defined by state law.

(c) **Individuals eligible for Part B of Medicare.** Birthing center services provided to Medicare eligible recipients should be billed directly to the fiscal agent.

*[OAR Docket #13-856; filed 5-21-13]*

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

*[OAR Docket #13-900]*

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**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
317:30-5-240. [AMENDED]
317:30-5-240.1. [AMENDED]
317:30-5-240.2. [AMENDED]
317:30-5-240.3. [AMENDED]
317:30-5-241. [AMENDED]
317:30-5-241.2. [AMENDED]
317:30-5-241.3. [AMENDED]
317:30-5-248. [AMENDED]
Part 25. Psychologists
317:30-5-276. [AMENDED]
Part 26. Licensed Behavioral Health Providers
317:30-5-281. [AMENDED]
Part 67. Behavioral Health Case Management Services
317:30-5-595. [AMENDED]
317:30-5-596.1. [AMENDED]
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N/A
**ANALYSIS:**
The Agency is proposing rule revisions to: (1) require that effective July 1, 2013 in order to qualify as a new Behavioral Health Rehabilitation Specialist (BHRS), individuals must be either an LBHP, CADC or certified as a Case Manager II by ODMHSAS. Individuals designated as BHRS prior to July 1, 2013 will have until July 1, 2014 to meet the new requirements; (2) Remove provisions allowing for grandfathering of BHRS and certified case managers who may have met certification requirements prior to the changes made over the years; (3) Enhance supervision requirements for BHRS by a LBHP; (4) Remove language that, as of July 1, 2013, will no longer be needed since the sunset provisions regarding specific dates when certain services will no longer be reimbursable when provided by Certified Alcohol and Drug Counselors (CADCs) will have passed; (5) Increase the number of available units of Medication Training and Support that are available for members from 1 unit per month to 2 units per month; (6) Add the ODMHSAS certification option for OPBH Agencies providing case management in lieu of national accreditation as well as to make minor "cleanup" changes to bring policy in line with current practices; (7) Align OHCA Behavioral Health Case Management (CM) policy with the certified behavioral health case manager certification policy proposed by ODMHSAS in Title 450 of the Administrative Code. There will now be more distinction within the levels of CM to better align education and training requirements for quality service provision and improve efficiency of the certification process by allowing Licensed Behavioral Health Professionals (LBHPs) and Certified Alcohol and Drug Counselors (CADCs) to provide case management services pursuant to the scope of their licensure/certification rather than requiring these individuals to go through the ODMHSAS certification process; and (8) Ensure compliance with laws related to confidentiality, including provisions requiring that services be provided in settings that assure and protect cnfidentiality.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

### 317:30-5-240. Eligible providers

All outpatient behavioral health providers eligible for reimbursement under OAC 317:30-5-240 et seq. must be an accredited or Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) certified organization/agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 ~~and~~or 3-415 of Title 43A of the Oklahoma Statutes and have a current contract on file with the Oklahoma Health Care Authority. Eligibility requirements for independent professionals (e.g., physicians and Licensed Behavioral Health Professionals), who provide outpatient behavioral health services and bill under their own national provider identification (NPI) number are covered under OAC 317:30-5-1 and OAC 317:30-5-275. Other outpatient ambulatory clinics (e.g. Federally Qualified Health Centers, Indian Health Clinics, school-based clinics) that offer outpatient behavioral health services are covered elsewhere in the agency rules.

**317:30-5-240.1. Definitions**

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

**"Accrediting body"** means one of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; or

(F) other OHCA approved accreditation.

**"Adult"** means an individual 21 and over, unless otherwise specified.

**"AOD"** means Alcohol and Other Drug.

**"AODTP"** means Alcohol and Other Drug Treatment Professional.

**"ASAM"** means the American Society of Addiction Medicine.

**"ASAM Patient Placement Criteria (ASAM PPC)"** means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

~~**"BH"** means behavioral health, which relates to mental, substance abuse, addictions, gambling, and other diagnosis and treatment.~~**"Behavioral Health (BH) Services"** means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

**"BHAs"** means Behavioral Health Aides.

**"BHRS"** means Behavioral Health Rehabilitation Specialist.

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

**"Child"** means an individual younger than 21, unless otherwise specified.

**"Client Assessment Record (CAR)"** means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member.

**"CM"** means case management.

~~**"CMHC's"**~~ **"CMHCs"** means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with ~~severe~~serious mental illnesses, and youth with serious emotional disturbances.

**"Cultural competency"** means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

**"DSM"** means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

**"EBP"** means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

**"EPSDT"** means the Medicaid Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

**"FBCS"** means Facility Based Crisis Stabilization.

**"FSPs"** means Family Support Providers.

**"ICF/MR"** means Intermediate Care Facility for the Mentally Retarded.

**"Institution"** means an inpatient hospital facility or Institution for Mental Disease (IMD).

**"IMD"** means Institution for Mental Disease as per 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)].

**"Level of Functioning Rating"** means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of Mental Health treatment. Either the Addiction Severity Index (ASI) or the Teen Addiction Severity Index (TASI), based on age, is the tool that links the clinical assessment to the appropriate level of Substance Abuse (SA) treatment.

**"LBHP"** means a Licensed Behavioral Health Professional.

**"MST"** means the EBP Multi-Systemic Therapy.

**"OAC"** means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.

**"Objectives"** means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

**"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"ODMHSAS contracted facilities"** means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

**"OHCA"** means the Oklahoma Health Care Authority.

**"OJA"** means the Office of Juvenile Affairs.

**"Provider Manual"** means the OHCA BH Provider Billing Manual.

**"RBMS"** means Residential Behavioral Management Services within a group home or therapeutic foster home.

**"Recovery"** means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

**"RSS"** means Recovery Support Specialist.

**"SAMHSA"** means the Substance Abuse and Mental Health Services Administration.

~~**"SED"** means Severe Emotional Disturbance.~~**"Serious Emotional Disturbance (SED)"** means a condition experienced by persons from birth to 18 that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either (A) or (B) below:

(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

~~**"SMI"** means Severely Mentally Ill.~~**"Serious Mental Illness (SMI)"** means a condition experienced by persons age 18 and over that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six months and be expected to persist for a year or longer.

(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(C) The adult must exhibit either (A) or (B) below:

(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations.

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

**"Trauma informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

**317:30-5-240.2. Provider participation standards**

(a) **Accreditation and certification status.** Any agency may participate as an OPBH provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1, or 3-415 of Title 43A of the Oklahoma Statutes;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statues;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;

(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;

(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under Federal regulation;

(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;

(8) Public Health Clinics and County Health Departments;

(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with Section(s) 3-317-, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statutes, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);

(2) Evidence Based Best Practices but not limited to:

(A) Assertive Community Treatment (OAC 450:55-1-1);

(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and

(C) Peer Support/Community Recovery Support;

(3) Systems of Care (OAC 340:75-16-46);

(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);

(5) Case Management (OAC 450:50-1-1);

(6) RBMS in group homes (OAC 377:10-7) or foster care settings (OAC 340:75-8-4);

(7) Day Treatment - CARF, JCAHO, or COA will be required as of December 31, 2009; and

(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, or COA will be required as of December 31, 2009.

(c) **Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, COA or AOA accreditation or ODMHSAS certification in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 or Title 43A of the Oklahoma Statutes will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

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

(3) ~~Effective 07/01/10, all~~All behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting requirements are set forth in OAC 317:30-3-2 and OAC 317:30-5-280.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

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

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

(A) One of the LBHPs;

(B) A BHRS or CADC, if individual or group rehabilitative services for behavioral health disorders are provided;

(C) An AODTP, if treatment of alcohol and other drug disorders is provided;

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

(E) The member for whom the services will be provided, and parent/guardian for those under 18 years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Treatment Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;

(E) Support Services; and

(F) Day Treatment/Intensive Outpatient.

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

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

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

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

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

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

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

**317:30-5-240. 3 Staff Credentials**

(a) **Licensed Behavioral Health Professional (LBHPs).** LBHPs are defined as follows:

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

(2) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (A) through (F) of this paragraph. The exemptions from licensure under 59 '1353(4) (Supp. 2000) and (5), 59 '1903(C) and (D) (Supp. 2000), 59 '1925.3(B) (Supp. 2000) and (C), and 59 '1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

(A) Psychology,

(B) Social Work (clinical specialty only),

(C) Professional Counselor,

(D) Marriage and Family Therapist,

(E) Behavioral Practitioner, or

(F) Alcohol and Drug Counselor.

(3) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) A Physician Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Certified Alcohol and Drug Counselors (CADC's).** CADC's are defined as having a current certification as a CADC in the state in which services are provided.

(c) **Behavioral Health Rehabilitation Specialists (BHRS).** BHRSs are defined as follows:

~~(1) Before 07/01/10:~~

~~(A) Bachelor or master degree in a behavioral health related field including, psychology, social work, occupational therapy, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency, rehabilitative services, sociology, school guidance and counseling, education, criminal justice family studies, earned from a regionally accredited college or university recognized by the United States Department of Education; or~~

~~(B) Bachelor or master degree that demonstrates the individual completed and passed equivalent college level course work to meet the degree requirements of (1) of this subsection, as reviewed and approved by OHCA or its designated agent; or~~

~~(C) A current license as a registered nurse in the state where services are provided; or~~

~~(D) Certification as an Alcohol and Drug Counselor. They are allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM-IV Axis I diagnosis; or~~

~~(E) Current certification as a Behavioral Health Case Manager II or III from ODMHSAS as described in OAC 317:30-5-595 (2)(C)(i) and 317:30-5-595 (2)(C) (ii).~~

(~~2~~1) ~~On or~~ After 7/01/10:

(A) Bachelor degree earned from a regionally accredited college or university recognized by the United States Department of Education and completion of the ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or

(B) CPRP (Certified Psychiatric Rehabilitation Practitioner) credential; or

(C) Certification as an Alcohol and Drug Counselor; or

(D) A current license as a registered nurse in the state where services are provided and completion

of the ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or

(E) If qualified as a BHRS prior to 07/01/10 and have a ODMHSAS ~~credential~~letter on file confirming that the individual meets BHRS qualifications.

(2) BHRS designations made between July 1, 2010 through June 30, 2013 will continue to be recognized until June 30, 2014 at which time 7/1/13 criteria must be met. Unless otherwise specified in rules, on or after 7/01/13, BHRS will be required to meet one of the following criteria:

(A) LBHP;

(B) CADC; or

(C) Current certification by ODMHSAS as a Behavioral Health Case Manager II as described in OAC 317:30-5-595(2).

(d) **Multi-Systemic Therapy (MST) Provider.** Masters level who work on a team established by OJA which may include Bachelor level staff.

(e) **Community Recovery Support Specialist (RSS).** The community/recovery support worker must meet the following criteria:

(1) High School diploma or GED;

(2) Minimum one year participation in local or national member advocacy or knowledge in the area of behavioral health recovery;

(3) current or former member of behavioral health services; and

(4) successful completion of the ODMHSAS Recovery Support Provider Training and Test.

(f) **Family Support and Training Provider (FSP).** FSPs are defined as follows:

(1) Have a high school diploma or equivalent;

(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(3) successful completion of ODMHSAS Family Support Training;

(4) pass background checks; and

(5) treatment plans must be overseen and approved by a LBHP; and

(6) must function under the general direction of a LBHP or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

(g) **Behavioral Health Aide (BHA).** BHAs are defined as follows:

(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or

(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and

(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(4) must be supervised by a bachelor's level individual with a minimum of two years case management or care coordination experience; and

(5) treatment plans must be overseen and approved by a LBHP; and

(6) must function under the general direction of a LBHP and/or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

**317:30-5-241. Covered Services**

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the ~~Behavioral Health Provider~~Prior Authorization Manual.

(d) All outpatient BH services must be provided following established medical necessity criteria. ~~Some~~Many outpatient behavioral health services ~~may~~ require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the ~~Behavioral Health Provider~~Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

**317:30-5-241.2. Psychotherapy**

(a) **~~Individual/Interactive~~ Psychotherapy.**

(1) **Definition.** ~~Individual~~ Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or

supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(2) **Definition.** ~~Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost the expressive language communication skills to explain his/her symptoms and response to treatment, requires the use of a mechanical device in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.~~ Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified professionals.** Psychotherapy must be provided by a Licensed Behavioral Health Professional (LBHP)~~With the exception of a qualified interpreter if needed, only the member and the Licensed Behavioral Health Professional (LBHP) should be present and the~~in a setting ~~must protect and assure~~that protects and assures confidentiality. ~~Certified Alcohol and Drug Counselors (CADC) are permitted to provide Individual/Interactive Psychotherapy for substance abuse (SA) only through June 30, 2013. Effective July 1, 2013 all Individual/Interactive Psychotherapy must be provided by LBHPs.~~ Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities. ~~Individual/Interactive counseling must be provided by a LBHP. CADCs are permitted to provide Individual/Interactive counseling for an alcohol or other drug disorders only through June 30, 2013.~~

(4) **Limitations.** A maximum of 6 units per day per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the Licensed Behavioral Health Professional (LBHP) should be present during the session.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP and two or more individuals to promote positive emotional or behavioral change. ~~CADCs are permitted to provide group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013; effective July 1, 2013 all group psychotherapy must be provided by LBHPs.~~ The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP. ~~CADCs are permitted to provide group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013. Effective July 1, 2013 all group psychotherapy must be provided by LBHPs.~~ Group Psychotherapy must take place in a confidential setting limited to the LBHP ~~or CADC conducting the service~~, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP and the member's family, guardian, and/or support system. ~~CADCs are permitted to provide family psychotherapy through June 30, 2013; effective July 1, 2013 all family psychotherapies must be provided by LBHPs.~~ It is

typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable. The provider may not bill any time associated with note taking and/or medical record upkeep. The provider may only bill the time spent in direct face-to-face contact. Provider must comply with documentation requirements listed in OAC 317:30-5-248.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

(A) Assessment, diagnostic and treatment plan services for mental illness and/or substance abuse disorders provided by LBHPs.

(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs.

(C) Substance abuse specific services are provided by LBHPs qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation training and education services to the extent the training and educational activities are closely and clearly related to the member's care and treatment, provided by a Behavioral Health Rehabilitation Specialist (BHRS), Certified Alcohol and Drug Counselor (CADC)or LBHP who meets the professional requirements listed in 317:30-5-240.3 or a Certified Behavioral Health Case Manager II.

(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.

(2) **Qualified professionals.**

(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:

(i) A licensed physician;

(ii) Registered nurse; and

(iii) One or more of the licensed behavioral health professionals (LBHP) listed in 30-5-240.3(a).

(B) The clinical team may also include any of the following paraprofessionals:

(i) ~~Masters or bachelors level~~ Behavioral Health Rehabilitation Specialist; or

(ii) Certified Behavioral Health Case Manager~~; or~~.

~~(iii) Certified Alcohol and Drug Counselor (CADC).~~

(C) The treatment plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD).

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit 2 times per month;

(ii) Crisis management services available 24 hours a day, 7 days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy - a minimum of 1 session per week;

(ii) Family therapy - a minimum of 1 session per week; and

(iii) Group therapy - a minimum of 2 sessions per week;

(C) Interchangeable ~~therapies~~services which include the following:

(i) Behavioral Health Case Management (face-to-face);

(ii) ~~BHRS/~~Behavioral health rehabilitation services/alcohol and other drug abuse education;

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, 7 days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one hour per week (additional hours of FT may be substituted for other day treatment services;

(ii) Group therapy at least two hours per week; and

(iii) Individual therapy at least one hour per week.

(B) Additional services are to include at least one of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) ~~BHRS~~Behavioral health rehabilitation services to include alcohol and other drug education if clinically necessary and appropriate

(iii) Behavioral health ~~Case~~case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements.** Service plans are required every three (3) months.

**317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services**

(a) **Definition.** ~~BHR are behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery.~~Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR

services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings that protect and assure confidentiality. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.

(b) **Psychosocial Rehabilitation (PSR).**

(1) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(~~1~~2) **Clinical restrictions.** This service is generally performed with only the members and the ~~BHRS~~qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(~~2~~3) **Qualified providers.** A BHRS, CADC, ~~or~~ LBHP may perform ~~BHR~~PSR, following development of a service plan and treatment curriculum approved by a LBHP. ~~Staff~~PSR staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology. The BHRS must have immediate access to a fully licensed LBHP who can provide clinical oversight of the BHRS and collaborate with the BHRS in the provision of services. A minimum of one monthly face-to-face consultation with a fully licensed LBHP is required.

(~~3~~4) **Group sizes.** The ~~minimum~~maximum staffing ratio is fourteen members for each ~~BHRS, CADC, or LBHP~~qualified provider for adults and eight to one for children under the age of eighteen.

(~~4~~5) **Limitations.**

(A) **Transportation.** Travel time to and from ~~BHR~~PSR treatment is not compensable. Group ~~psychosocial rehabilitation~~PSR services do not qualify for the OHCA transportation program, but ~~they~~OHCA will arrange for transportation for those who require specialized transportation equipment. ~~A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.~~

(B) **Time.** Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location.** In order to develop and improve the member's community and interpersonal functioning and self care abilities, ~~rehabilitation~~PSR services may take place in settings away from the outpatient behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the ~~BHRS, CADC, or LBHP~~qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Eligibility for PSR services.** PSR services are intended for adults with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. The following members are not eligible for PSR services:

(i) Residents of ICF/MR facilities, unless authorized by OHCA or its designated agent;

(ii) children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity;

(iii) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated agent;

(iv) inmates of public institutions;

(v) members residing in inpatient hospitals or IMDs; and

(vi) members residing in nursing facilities.

(~~D~~E) **Billing limits.**~~Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic foster home are not eligible for this service, unless allowed by OHCA or its designated agent.~~PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR services authorized under this Section are separate and distinct from, but should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in Day Treatment or Partial Hospitalization Programs. Children under an ODMHSAS Systems of Care program and adults residing in residential care facilities may be prior authorized additional units as part of an intensive transition period. PSR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR**. The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual PSR**. The maximum is six units per day. ~~Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.~~

(iii) **Per-Member service levels and limits.** Unless otherwise specified, group and/or individual PSR services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on PSR services are established based on the level for which the member has been approved. There are no limits on PSR services for individuals determined to be Level 4.

(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.

(~~E~~F) ~~**Documentation requirements**~~**Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for intensive and skills training ~~outpatient~~ mental health, substance abuse or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:

(i) Curriculum sessions attended each day and/or dates attending during the week;

(ii) Start and stop times for each day attended and the physical location in which the service was rendered;

(iii) Specific goal(s) and objectives addressed during the week;

(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;

(v) Member satisfaction with staff intervention(s);

(vi) Progress, or barrier to, made towards goals, objectives;

(vii) New goal(s) or objective(s) identified;

(viii) Signature of the lead ~~BHRS~~qualified provider; and

(ix) Credentials of the lead ~~BHRS~~qualified provider~~.~~;

(G)**Additional documentation requirements.**

(i) a list/log/sign in sheet of participants for each Group rehabilitative session and facilitating qualified provider must be maintained; and

(ii) Documentation of ongoing consultation and/or collaboration with a LBHP related to the provision of PSR services.

(H) **Non-Covered Services.** The following services are not considered BHR and are not reimbursable:

(i) Room and board;

(ii) educational costs;

(iii) supported employment; and

(iv) respite.

(c) **Outpatient Substance Abuse Rehabilitation Services.**

(1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Limitations.** Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified providers.** BHRS, CADC or LBHP.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on services are established based on the level for which the member has been approved. There are no limits on substance abuse rehabilitation services for individuals determined to be Level 4.

(6) **Documentation requirements.** Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

(~~b~~d) **Medication training and support.**

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, advanced practice nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review

must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities.

(B) ~~One unit is~~Two units are allowed per month per patient.

(C) Medication Training & Support is not allowed to be billed on the same day as ~~pharmacological management~~an evaluation and management (E/M) service provided by a psychiatrist.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, an advanced practice nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements** - Medication Training and Support documented review must focus on:

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

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

All outpatient behavioral health services must be reflected by documentation in the ~~members~~member's records.

(1) For Behavioral Health Assessments (see OAC 317:30-5-241), no progress notes are required.

(2) For Behavioral Health Services Plan(see OAC 317:30-5-241), no progress notes are required.

(3) Treatment Services must be documented by progress notes.

(A) Progress notes shall chronologically describe the services provided, the member's response to the services provided and the member's progress, or lack of, in treatment and must include the following:

(i) Date;

(ii) Person(s) to whom services were rendered;

(iii) Start and stop time for each timed treatment session or service;

(iv) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or photocopied signatures are allowed. Electronic signatures are acceptable following OAC 317:30-3-4.1 and 317:30-3-15;

(v) Credentials of therapist/service provider;

(vi) Specific service plan need(s), goals and/or objectives addressed;

(vii) Services provided to address need(s), goals and/or objectives;

(viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;

(ix) Member (and family, when applicable) response to the session or intervention;

(x) Any new need(s), goals and/or objectives identified during the session or service.

(4) In addition to the items listed above in this subsection:

(A) Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment;

(B) a list/log/sign in sheet of participants for each Group rehabilitative or psychotherapy session and facilitating ~~BHRS, LBHP, or CADC~~qualified provider must be maintained; and

(C) for medication training and support, vital signs must be recorded in the medical record, but are not required on the behavioral health services plan;

(5) Progress notes for intensive and skills training ~~out-patient~~ behavioral health, substance abuse, or integrated BHR programs may be in the form of daily or weekly summary notes and must include the following:

(A) Curriculum sessions attended each day and/or dates attended during the week;

(B) Start and stop times for each day attended;

(C) Specific goal(s) and/or objectives addressed during the week;

(D) Type of Skills Training provided each day and/or during the week including the specific curriculum used with the member;

(E) Member satisfaction with staff intervention(s);

(F) Progress or barriers made toward goals, objectives;

(G) New goal(s) or objective(s) identified;

(H) Signature of the lead ~~BHRS~~qualified provider; and

(I) Credentials of the lead ~~BHRS~~qualified provider.

(6) Concurrent documentation between the clinician and member can be billed as part of the treatment session time, but must be documented clearly in the progress notes and signed by the member (or note if the member is unable/refuses to sign).

## PART 25. PSYCHOLOGISTS

**317:30-5-276. Coverage by category**

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth

in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the ~~Behavioral Health Provider~~ Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the ~~Behavioral Health Provider~~Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** There is no coverage for adults for services by a psychologist.

(c) **Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider per member. If there has been a break in service over a six month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) ~~Individual and/or Interactive psychotherapy~~Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. ~~Individual psychotherapy~~Psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a SoonerCare eligible child as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six patients for children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the ~~Behavioral Health Provider~~Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the ~~Behavioral Health Provider~~Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill children.

(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

## PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

**317:30-5-281. Coverage by Category**

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the ~~Behavioral Health Provider~~Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the ~~Behavioral Health Provider~~Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** There is no coverage for adults for services by a LBHP.

(c) **Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social and Level of Care Assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) ~~Individual and/or Interactive psychotherapy~~Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by apsychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the ~~Behavioral Health Provider~~Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the ~~Behavioral Health Provider~~Prior Authorization Manual. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

## PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

**317:30-5-595. Eligible providers**

Services are provided by outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.

(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

~~(A) Agencies must hold current accreditation appropriate to outpatient behavioral health from JCAHO, CARF, COA, or AOA, and maintain the standards of the accreditation at all times.~~

(~~B~~A) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(~~C~~B) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals must be community based.

(~~D~~C) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.

(~~E~~D) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.

(~~F~~E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(~~G~~F) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2.

(2) **Provider Qualifications.**

~~(A) **Service provider education and experience requirements if certified before July 1, 2001.** For case management services to be compensable by SoonerCare, the case manager performing the service must maintain current case management certification from the ODMHSAS and have the following education and experience requirements apply:~~

~~(i) Associate degree in a related human service field, OR;~~

~~(ii) Two years of college education plus two years or more human service experience, OR;~~

~~(iii) Bachelors degree in a related human service field plus one year or more human service experience, OR;~~

~~(iv) Masters degree in a related human service field.~~

~~(B) **Service provider education and experience requirements if certified after July 1, 2001 and before July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and have a:~~

~~(i) Bachelors or masters degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling; OR~~

~~(ii) A current license as a registered nurse in Oklahoma with experience in behavioral health care; OR~~

~~(iii) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM IV Axis I diagnosis; and~~

~~(iv) Current case management certification from the ODMHSAS.~~

(~~C~~) ~~**Service provider education and experience requirements if certified after July 1, 2007.**~~ For behavioral health case management services to be compensable by SoonerCare, the ~~case manager~~provider performing the service must be a LBHP, CADC, or have and maintain a current certification as a ~~behavioral health case manager certification~~Case Manager II (CM II) or Case Manager I (CM I) from the ODMHSAS ~~and meet either (i), (ii), or (iii) below, and (iv):~~. Case Manager Certifications issued prior to July 1, 2013 will continue to be recognized in addition to the certifications noted above until June 30, 2014. The requirements for obtaining these certifications are as follows:

~~(i) Certified Behavioral Health Case Manager III meets the Licensed Behavioral Health Professional status as defined at OAC317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.~~

(~~ii~~A) Certified Behavioral Health Case Manager II (CM II) ~~a bachelors or masters degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, education and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.(After July 1, 2010: Any bachelors or masters degree earned from a regionally accredited college or university recognized by the USDE).~~must meet the requirements in (i), (ii) or (iii) below:

(i) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a Bachelor's or Master's degree in education with at least nine (9) hours of college credit in a behavioral health field; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(ii) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(iii) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and current certification as a Certified Psychiatric Rehabilitation Practitioner (CPRP); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(~~iii~~B) Certified Behavioral Health Case Manager I meets the requirements in either ~~(I)~~(i) or ~~(II)~~(ii), and ~~(III)~~(iii):

(~~I~~i) completed 60 college credit hours; or

(~~II~~ii) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(~~III~~iii) ~~passes the ODMHSAS web-based Case Management Competency Exam, and completes~~Completes~~14 hours~~two days of ODMHSAS specified ~~CM~~behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(~~D~~C) **Wraparound Facilitator Case Manager** - LBHP, CADC, or meets the qualifications for CM II ~~or CM III~~ and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS;

(~~E~~D) **Intensive Case Manager** - LBHP, CADC or meets the provider qualifications of a Case Manager II ~~or III~~ and has the following:

(i) A minimum of two years Behavioral Health Case Management experience, crisis diversion experience, and

(ii) must have attended the ODMHSAS six hours Intensive case management training.

(~~F~~E) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

**317:30-5-596.1. Prior authorization [REVOKED]**

~~(a) Prior to providing behavioral health case management services provider must submit to OHCA, or its designated agent member information which includes but is not limited to the following:~~

~~(1) Complete multi-axial DSM diagnosis with supportive documentation and mental status examination summary;~~

~~(2) Treatment history;~~

~~(3) Current psycho social information;~~

~~(4) Psychiatric history; and~~

~~(5) Fully developed case management service plan, with goals, objectives, and time frames for services.~~

~~(b) SoonerCare members who are eligible for services will be considered for behavioral health case management services after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be eligible for case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. A fully developed individual plan of service is not required prior to providing the service. The~~

~~provider will be given a time frame to develop the individual plan of service while working with the child and his/her family.~~

*[OAR Docket #13-900; filed 5-23-13]*

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

*[OAR Docket #13-835]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 27. Independent Licensed Physical Therapists
317:30-5-291. [AMENDED]
Part 28. Occupational Therapy Services
317:30-5-296. [AMENDED]
Part 77. Speech and Hearing Services
317:30-5-676. [AMENDED]
**(Reference APA WF # 12-07)**
**AUTHORITY:**
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Part 27. Independent Licensed Physical Therapists
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N/A
**ANALYSIS:**
Agency policy on therapy services is revised to comply with federal law, which requires a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered. Policy is also revised to require a prior authorization for speech therapy services.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS

**317:30-5-291. Coverage by category**

Payment is made to registered physical therapists 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. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

### PART 28. 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. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record

that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

## PART 77. SPEECH AND HEARING SERVICES

**317:30-5-676. Coverage by category**

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** ~~Initial therapy evaluations and the first three therapy visits do not require prior authorization. All therapy services following the initial evaluation and first three visits must be preauthorized prior to continuation of service.~~All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(B) **Speech/Language Services.** Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

*[OAR Docket #13-835; filed 5-21-13]*

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

*[OAR Docket #13-855]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 33. Transportation by Ambulance
317:30-5-335.1. [AMENDED]
317:30-5-336.4. [AMENDED]
317:30-5-336.5. [AMENDED]
317:30-5-336.13. [AMENDED]
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**ANALYSIS:**
OHCA rules are revised to update ambulance transportation policy for clarity and consistency. Proposed revisions add a definition for emergency, and include language that will require a prior authorization for out of state transports. Additional revisions include clean-up to remove outdated policy to align with current practice and to clarify medically necessity requirements for air ambulance services..
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 33. TRANSPORTATION BY AMBULANCE

**317:30-5-335.1. Definitions**

The following words and terms, when used in this subchapter shall have the following meaning, unless the context clearly indicates otherwise.

**"Ambulance"** means a motor vehicle, watercraft, or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

**"Bed confined"** means that the member is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. The term bed confined is not synonymous with bed rest or non-ambulatory.

**"Continuous or round trip"** means an ambulance service in which the member is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the member is then transported to a more appropriate facility for care or back to the place of origin.

**"Emergency/ Emergent"** means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the member's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

**"Emergency transfer"** means the movement of an acutely ill or injured member from the scene to a health care facility (pre-hospital), or the movement of an acutely ill or injured member from one health care facility to another health care facility (inter-facility).

**"Loaded mileage"** means the number of miles for which the member is transported in the ambulance.

**"Locality"** means the service area surrounding the facility from which individuals normally travel or are expected to travel to seek medical care.

**"Medically necessary transport"** means an ambulance transport that is required because no other effective and less costly mode of transportation can be used due to the member's medical condition. The transport is required to transfer the member to and/or from a medically necessary service not available at the primary location.

**"Nearest appropriate facility"** means that the receiving institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a member of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

**"Non-emergency transfer"** means the movement of any member in an ambulance other than an emergency transfer.

**"Stretcher service"** means a non-emergency transport by a ground vehicle that is approved by the OSDH which is designed and equipped to transport individuals on a stretcher or gurney type apparatus that is operated to accommodate an incapacitated or disabled person who does not require medical monitoring, aid, care or treatment during transport.

**317:30-5-336.4. Transport outside of locality**

(a) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.

(b) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.

(c) Any transportation which begins or ends outside of the Oklahoma geographic border requires prior authorization. The exception to this rule is if transportation begins or ends within 100 miles of Oklahoma's geographic border, no prior authorization is required.

**317:30-5-336.5. Levels of ambulance service, ambulance fee schedule and base rate**

(a) In accordance with the Oklahoma Emergency Response System Development Act of 2005, §63 OS 1-2503, a license may be issued for basic life support, intermediate life support, paramedic life support, specialized mobile intensive care units, or stretcher aid vans.

(b) Payment is made at the lower of the provider's usual and customary charge or the OHCA fee schedule for SoonerCare compensable services.

(1) The ambulance provider bills one base rate procedure. Levels of service base rates are defined at 42 CFR 414.605.

(2) The base rate must reflect the level of service rendered, not the type of vehicle in which the member was transported~~, except in those localities where local ordinance requires Advanced Life Support (ALS) as the minimum standard of service~~.

**317:30-5-336.13. Non-covered services**

~~(a) Transportation by ambulance is not covered when the member's condition did not require that level of transportation and another mode of transportation would suffice.~~

(~~b~~a) Ambulance transportation from residence to residence is not covered except for transfers from nursing home to nursing home when the transferring facility is not certified.

(~~c~~b) Payment will not be made for ambulance transportation determined not to be medically necessary.

(~~d~~c) Transportation to a funeral home, mortuary, or morgue is not covered.

*[OAR Docket #13-855; filed 5-21-13]*

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

*[OAR Docket #13-833]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 35. Rural Health Clinics
317:30-5-355.1. [AMENDED]
317:30-5-359.2. [AMENDED]
317:30-5-361. [AMENDED]
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N/A
**ANALYSIS:**
Rural Health Clinics policy is revised to allow RHC's to bill lab services separately, as they can under Medicare. RHC policy is also updated to eliminate language that is inapplicable to OHCA's current operational practices.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 35. RURAL HEALTH CLINICS

**317:30-5-355.1. Definition of services**

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. ~~In all instances where possible, SoonerCare defines a Rural Health Clinic service the same as Medicare as set out in Information Bulletin 93-15 issued by Blue Cross/Blue Shield of Oklahoma, Medicare Part A.~~ These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice nurses (APNs), physician assistants (PAs), nurse midwives (NMs) or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of APNs and PAs (including services furnished by nurse midwives);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs~~; and~~.

~~(viii) Laboratory tests essential to the immediate diagnosis and treatment of the member including:~~

~~(I) chemical examinations of urine by stick or tablet,~~

~~(II) hemoglobin or hematocrit,~~

~~(III) blood sugar,~~

~~(IV) examination of stool specimens for occult blood,~~

~~(V) pregnancy tests,~~

~~(VI) primary culturing for transmittal to a certified laboratory.~~

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of a RHC practitioner who is a clinic employee:

(i) prenatal and postpartum care;

(ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for members under 21;

(iii) family planning services;

(iv) medically necessary screening mammography and follow-up mammograms when medically necessary.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker are covered if the service or supply is:

(i) a type commonly furnished in physicians' offices;

(ii) a type commonly rendered either without charge or included in the rural health clinic's bill;

(iii) furnished as an incidental, although integral, part of a physician's professional services;

(iv) ~~A separate charge is allowable for immunizations covered under EPSDT. Also, injections not otherwise discussed below must be billed separately using the appropriate HCPC codes. However, drugs~~Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

(i) the RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;

(ii) the services are rendered to members who are homebound;

(iii) the member is furnished nursing care on a part time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(iv) the services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** A Rural Health Clinic must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the SoonerCare program. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

(i) dental services for members under age 21;

(ii) optometric services;

(iii) clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification~~(other than the specific laboratory tests set out for RHC certification and covered as RHC services)~~;

(iv) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) durable medical equipment;

(vi) emergency ambulance transportation;

(vii) prescribed drugs;

(viii) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) specialized laboratory services furnished away from the clinic;

(x) inpatient services;

(xi) outpatient hospital services.

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under age 21. Encounters are billed as one of the following:

(i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This

includes the refraction and medical eye health evaluation. Glasses must be billed separately.

(C) Services listed in (a)(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

**317:30-5-359.2. Reimbursement**

(a) **Provider-based clinics.** Interim payments for provider-based clinics will be made for RHC "core" services based on an all-inclusive visit fee established by ~~the Medicaid agency~~reference to payments to other Rural Health Clinics in the same or adjacent areas or by cost reporting methods. The interim rate for core services will be reviewed and revised as appropriate, based on cost data from an initial cost report. ~~Interim payments will also be made for other ambulatory services furnished by the clinic on a reasonable charge basis in accordance with Medicaid fee schedule guidelines. There will be a separate year-end settlement for RHC services and other ambulatory services provided at the RHC on the basis of Medicare cost reimbursement principles.~~ Costs will be determined from the parent hospital's cost-to-charge ratios per the HCFA-2552 Medicare (or Medicaid, when filed) Worksheet C, Part 1, Computation of Ratio of Costs to Charges. Lower of cost or charge provision will be calculated using the lesser of costs or two times charges (as determined by averaged cost to charge ratios based on FY 95 cost reports). After the initial year and the per visit rate are established, the rate will be updated annually by the increase in the MEI.

(b) **Independent clinics.** Interim payments for independent clinics will be made for RHC "core" services based on the all-inclusive rate established by ~~the Medicare intermediary,~~reference to payments to other Rural Health Clinics in the same or adjacent areas or by cost reporting methods. The interim rate for core services will be reviewed and revised as appropriate, based on cost data from an initial 12 month cost report and payments may be subject to adjustment at the end of the reporting period ~~using actual costs per visit applied to the Medicaid visits~~. After the initial year and the per visit rate are established, the rate will be updated annually by the increase in the MEI. For clinics that offer "other ambulatory" services and preventive services, payment will be made on a reasonable charge basis in accordance with Medicaid fee schedule guidelines.

**317:30-5-361. Billing**

(a) **Encounters.** Payment is made for one type of encounter per member per day. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

(b) **Services billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.

(1) **Laboratory.** The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services ~~which are not included in the all-inclusive rate~~ must be itemized separately using the appropriate CPT or HCPCS code.

(2) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(3) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).

(B) Insertion and implantation of a subdermal contraceptive device.

(C) Removal, implantable contraceptive devices.

(D) Removal, with reinsertion, implantable contraceptive device.

(E) Insertion of intrauterine device (IUD).
(F) Removal of intrauterine device.
(G) ParaGard IUD.
(H) Progestasert IUD.

(5) **Glasses.** Glasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code.

(6) **Telemedicine.** The originating site facility fee for telemedicine services is not a rural health clinic service. When a rural health clinic serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.

*[OAR Docket #13-833; filed 5-21-13]*

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

*[OAR Docket #13-836]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-4. [AMENDED]
Part 39. Skilled Nursing Services
317:30-5-394. [AMENDED]
Part 41. Family Support Services
317:30-5-413. [AMENDED]
Part 43. Agency Companion, Specialized Foster Care, Daily Living Supports, Group Homes, and Community Transition Services
317:30-5-424. [AMENDED]
Part 51. Habilitation Services
317:30-5-483. [AMENDED]
Part 53. Specialized Foster Care
317:30-5-499. [AMENDED]
Part 55. Respite Care
317:30-5-519. [AMENDED]
Part 59. Homemaker Services
317:30-5-538. [AMENDED]
**(Reference APA WF # 12-13)**
**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 111-148
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**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Agency policy is revised to remove references to the ICD-9 International Classification of Diseases diagnosis coding, which is being replaced by a new system of coding, ICD-10.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 1. PHYSICIANS

**317:30-5-4. Procedure and diagnosis coding**

(a) The Authority uses the Health Care Financing Administration Common Procedure Coding System (HCPCS). This system is a five digit coding system using numbers and letters. Modifiers are used to further identify services. There are two sets of codes in the HCPCS system which are maintained by different organizations. First are the CPT codes, established and maintained by the American Medical Association. Second, are the second level HCPCS codes assigned and maintained by the Federal Health Care Financing Administration, the American Dental Association, etc. These codes are common to all Medicare Carriers.

(b) The coding process in the CPT includes a description of the various levels of services and a guide to selecting the codes which appropriately describe the level of services provided. Normally a physician will perform office, hospital, nursing home and emergency room visits which include the complete range of levels of service from brief to comprehensive. Physicians who routinely bill only for higher levels of care may appear on utilization reports and will be reviewed and/or investigated to determine if the service rendered matches the level of service claimed.

(c) The Authority accepts the ~~ICD-9-CM~~ International Classification of Diseases diagnosis coding currently used by the Centers for Medicare and Medicaid Services.

### PART 39. SKILLED NURSING SERVICES

**317:30-5-394. Diagnosis codes [REVOKED]**

~~The primary ICD-9-CM diagnosis code for Skilled Nursing Services is 319 (Mental Retardation). This code must be~~

~~entered in Item 21 on the HCFA-1500. Any secondary diagnosis may also be entered in this field.~~

## PART 41. FAMILY SUPPORT SERVICES

**317:30-5-413. Diagnosis codes [REVOKED]**

~~The primary ICD-9-CM diagnosis code for Family Support Services is 319 (Mental Retardation). This code must be entered in Item 21 on the HCFA-1500. Any secondary diagnosis can also be entered in this field.~~

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

**317:30-5-424. Diagnosis code [REVOKED]**

~~The ICD-9-CM diagnosis code for residential supports is 319 (mental retardation). This code must be entered in field 21 on the Form CMS-1500.~~

## PART 51. HABILITATION SERVICES

**317:30-5-483. Diagnosis codes [REVOKED]**

~~The primary ICD-9-CM diagnosis code for Habilitation Services is 319 (Mental Retardation). This code must be entered in Item 21 on the HCFA-1500. Any secondary diagnosis can also be entered in this field.~~

## PART 53. SPECIALIZED FOSTER CARE

**317:30-5-499. Diagnosis code [REVOKED]**

~~The ICD-9-CM diagnosis code for specialized foster care is 319 (mental retardation). This code must be entered in field 21 on Form CMS-1500.~~

## PART 55. RESPITE CARE

**317:30-5-519. Diagnosis code [REVOKED]**

~~The ICD-9-CM diagnosis code for respite care is 319 (mental retardation). This code must be entered in field 21 on Form CMS-1500.~~

## PART 59. HOMEMAKER SERVICES

**317:30-5-538. Diagnosis codes [REVOKED]**

~~The primary ICD-9-CM diagnosis code for homemaker services is 319 (mental retardation). This code must be entered in field 21 on Form CMS-1500. Any secondary diagnosis can also be entered in this field.~~

*[OAR Docket #13-836; filed 5-21-13]*

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

*[OAR Docket #13-862]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 4. Long Term Care Hospitals
317:30-5-66.[AMENDED]
317:30-5-67.[AMENDED]
**(Reference APA WF # 12-42)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Sections 5003 through 5016 and Section 5022 of Title 63 of the Oklahoma Statutes; Medicaid State Plan as approved by the Centers for Medicare and Medicaid Services (CMS)
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**ANALYSIS:**
The proposed rule change amends rules regarding Long Term Care (LTC) Sub-Acute Hospitals in order to update reimbursement language from a prospective per diem methodology to a cost based methodology. This revision is proposed to bring policy in alignment with the approved Medicaid State Plan reimbursement methodology and current practice. Additionally, the proposed rule change clarifies cost reporting requirements related to the reimbursement methodology for these facilities.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 4. LONG TERM CARE HOSPITALS

**317:30-5-66. Reimbursement for inpatient hospital subacute services**

Reimbursement for inpatient hospital subacute services is made based on cost reports submitted to the OHCA.~~a prospective per diem. The rate will be calculated as a percent of the statewide median total **rehabilitation per diem** rate paid to non-teaching acute care hospitals without burn and without NICU units. The percent will be based upon cost report data from a base year.~~ The cost reports will be reviewed annually to ensure that the ~~percent~~interim rate is appropriate for the current cost/case mix of care for these facilities and to make settlement to the facility based on total allowable costs under Mecicare/Medicaid cost principles.

**317:30-5-67. Cost reports**

Each long term care facility is required to submit, on uniform cost reports designed by the Authority, an annual cost report for the fiscal year just completed. The fiscal year is July 1 through June 30. The reports must be submitted to the Authority on or before the first day of September.

(1) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation.

(2) Cost report forms and instructions are mailed annually to each facility before the first of July. The completed forms are to be returned to the Authority, Attention: Reimbursement and Audit.

(3) Normally, all ordinary and necessary expenses incurred in the conduct of an economical and efficiently operated business are recognized as allowable.

(4) All reports are subject to on-site audits and are deemed public records.

(A) Only "allowable costs" may be included in the cost reports, (costs should be net of any offsets of credits). Allowable costs include all items of Medicaid-covered expense which pediatric long term care hospitals incur in the provision of routine services. "Routine services" include, but are not limited to:

(i) regular room,

(ii) dietary and nursing services,

(iii) minor medical and surgical supplies,

(iv) over-the-counter medications,

(v) transportation, and

(vi) the use and maintenance of equipment and facilities essential to the provision of routine care.

(B) Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.)

(C) Ancillary items reimbursed outside the long term care hospital rate should not be included in the cost report and are not allowable costs.

(D) A supplemental addendum to the cost report, including all inpatient and outpatient charges by payor source, will be included with the annual cost report.

*[OAR Docket #13-862; filed 5-21-13]*

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

*[OAR Docket #13-831]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 51. Habilitation Services
317:30-5-482. [AMENDED]
**(Reference APA WF # 12-01A)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act *The Hissom Memorial Center et al.*, in case number 85-CV-437-GKF, in the United States District Court for the Northern District of Oklahoma
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**ANALYSIS:**
Permanent rule revisions are proposed to provide an exception for members of the Homeward Bound Waiver receiving Habilitation Training Specialist (HTS) services. The rule revision will allow the HTS to provide more than 40 hours of service per week, when the HTS resides in the same home as the member. The rule revision is promulgated as the result of a lawsuit filed on behalf of class members of the Homeward Bound waiver.

**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 51. HABILITATION SERVICES

**317:30-5-482. Description of services**

Habilitation services include the services identified in (1) through (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).

(1) **Dental services.** Dental services are provided per OAC 317:40-5-112.

(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure to practice dentistry in Oklahoma by the Board of Governors of Registered Dentists of Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) oral examination;

(ii) bite-wing x-rays;

(iii) prophylaxis;

(iv) topical fluoride treatment;

(v) development of a sequenced treatment plan that prioritizes:

(I) elimination of pain;

(II) adequate oral hygiene; and

(III) restoration or improved ability to chew;

(vi) routine training of member or primary caregiver regarding oral hygiene; and

(vii) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP), in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of their practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as all medical and osteopathic physicians, physician assistants and other licensed professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant within their employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have a current non-restrictive licensure with the Oklahoma State Board of Medical Licensure and Supervision. The physical therapist assistant must be employed by the physical therapist.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapist assistants, within the limits of their practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group, six person maximum, formats.

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

(ii) Psychological services are authorized for a period not to exceed six months.

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the DDSD area manager based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDSD case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services (OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours (96 units) of service per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours (48 units) may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours (560 units) of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a non-restrictive license to practice medicine in Oklahoma. Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, and medication and prescription management and consultation provided to members who are eligible. Services are provided in any community setting as specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech/language services requires non-restrictive licensure as a speech/language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor/feeding activities provided to members who are eligible. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(i) For purposes of this Section, a practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants and other licensed professionals with prescriptive authority to order speech/language services in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet the unique needs of members;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2), unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight from a contracted agency staff with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment will not be made for:

(I) routine care and supervision that is normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours. Exceptions may be authorized when needed for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, and improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) DDSD case management supervisor review and approval is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an oversight agency approved by the OHCA. For pre-authorized HTS services, the service:

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

(C) **Coverage limitations.** HTS services are authorized as specified in OAC 317:40-5-110, 317:40-5-111, and 317:40-7-13, and OAC 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment including on call duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).** SD HTS are provided per 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).** SD GS are provided per 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to members who are eligible. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a practitioner's prescription.

(i) For purposes of this Section, a practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:

(I) join the general work force; or

(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.

(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.

(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.

(iv) Documentation must be maintained in the record of each member receiving this service noting that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(v) Services include:

(I) center-based prevocational services as specified in OAC 317:40-7-6;

(II) community-based prevocational services as specified in OAC 317:40-7-5;

(III) enhanced community-based prevocational services as specified in OAC 317:40-7-12; and

(IV) supplemental supports as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members

receiving services through HCBS Waiver, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching as specified in OAC 317:40-7-7;

(II) enhanced job coaching as specified in OAC 317:40-7-12;

(III) employment training specialist services as specified in OAC 317:40-7-8; and

(IV) stabilization as specified in OAC 317:40-7-11.

(iii) Supported employment services furnished under HCBS Waiver are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving this service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) payments that are passed through to users of supported employment programs; or

(III) payments for vocational training that are not directly related to a member's supported employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed $25,000 per Plan of Care year. The DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) Therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDSD. Providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2;

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities; and

(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(ii) The member's IP must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) DDSD case management supervisor review and approval is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements set forth in 63 O.S. § 1-873 *et seq.* and comply with OAC 310:605; and

(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers in order to promote maximum level of independence and

function. Services are provided in a non-residential setting separate from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are typically furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the member's IP.

*[OAR Docket #13-831; filed 5-21-13]*

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

*[OAR Docket #13-852]*

**RULEMAKING ACTION:**
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**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
317:30-5-699.[AMENDED]
317:30-5-700.[AMENDED]
**(Reference APA WF # 12-25)**
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SoonerCare dental rules are revised to update pulp cap language to align with current practice and language contained in OAC 317:30-5-699. In addition, OAC 317:30-5-700 (C) Orthodontic rules are revised to align OHCA current verification of continuing education policy with the Oklahoma Board of Dentistry prerequisite licensing requirement. The amendment change to OHCA policy will require all General and Pediatric dentists providing orthodontic care to complete 60 hours of continuing education hours and at least 20 hours of continuing education in the field of orthodontics every (3) three year cycle.

**CONTACT PERSON:**
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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 79. DENTISTS

**317:30-5-699. Restorations**

(a) **Use of posterior composite resins.** Payment is not made for certain restorative services when posterior composite resins are used in restorations involving:

(1) replacement of any occlusal cusp or

(2) sub-gingival margins

(b) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 18 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document use of rubber dam isolation in daily treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

(c) **Coverage for dental restorations.** Restoration of incipent lesions is not considered medically necessary treatment. Any diagnosis not supported by radiographs requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.

(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.

(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

(d) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These two codes are the only codes that may be used for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(e) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect pulp cap code requires specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes are verified on a post payment review.

**317:30-5-700. Orthodontic services**

(a) In order to be eligible for SoonerCare Orthodontic services, members must be referred through a primary care dentist; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

(1) the member has had a caries free initial visit;or

(2) has all decayed areas restored and has received a six month hygiene evaluation indicating the member remains caries free; and

(3) has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The Oklahoma SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

(1) a handicapping malocclusion, as measured on the Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 30;

(2) any classification secondary to cleft palate or other maxillofacial deformity;

(3) if a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;

(4) fixed appliances only; and

(5) permanent dentition with the exception of cleft defects.

(d) Reimbursement for Orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice and submit for review at least 25 successfully completed comprehensive cases. Of these 25 comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping Malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one of each of the following types:

(i) deep overbite where multiple teeth are impinging upon the soft tissue of the palate;

(ii) impacted canine or molar requiring surgical exposure;

(iii) bilateral posterior crossbite requiring fixed rapid palatal expansion; and

(iv) skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) ~~Verification of the continuing education hours and the number of cases completed are reviewed by the OHCA Dental Unit every two years.~~The Oklahoma Health Care Authority requires all General dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that least 20 continuing education hours in the field of orthodontics has been completed. All verification reports must be submitted to OHCA Dental unit every three years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of 24 months of therapy.

(e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare Program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year;

(4) The member must be SoonerCare-eligible and under 18 years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired:

(A) Members receive a permanent Medical Identification Card;

(B) It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age 18.

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

*[OAR Docket #13-852; filed 5-21-13]*

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

*[OAR Docket #13-860]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-761.[AMENDED]
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317:30-5-764.[AMENDED]
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OHCA rules for the ADvantage Waiver are revised to establish a maximum annual reimbursement cap for Hospice services in order to prevent members from exceeding the individual waiver cost limit. Currently hospice service expenditures are the primary basis for members exceeding the individual ADvantage Waiver cost limit. Rules are also revised to disallow an active Power of Attorney from being a paid caregiver for members self-directing their services, increase the maximum hours of Adult Day Health Services from six hours per day to eight hours per day and add Skilled Nursing as an allowable service.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

**317:30-5-761. Eligible providers**

ADvantage Program service providers, except pharmacy providers, must be certified by the ADvantage Program ADvantage Administration (AA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process ~~verifies~~must verify that the provider meets licensure, certification and training standards as specified in the waiver document and agrees to ADvantage Program Conditions of Participation. Providers must obtain programmatic certification to be ADvantage Program certified.

(2) The provider financial certification process ~~verifies~~must verify that the provider uses sound business management practices and has a financially stable business. All providers, except for NF Respite, Medical Equipment and Supplies, and Environmental Modification providers, must obtain financial certification to be ADvantage Program certified.

(3) Providers may fail to gain or may lose ADvantage Program certification due to failure to meet either programmatic or financial standards.

(4) At a minimum, provider financial certification is reevaluated annually.

(5) The Oklahoma Department of Human Services (OKDHS)/Aging Services Division (ASD) evaluates Adult Day Care and Home Delivered Meal providers for compliance with ADvantage programmatic certification requirements. For Assisted Living Services provider programmatic certification, the ADvantage program relies in part upon the Oklahoma State Department of Health/Protective Health Services for review and verification of provider compliance with ADvantage standards for Assisted Living Services providers. Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, CD-PASS, and NF Respite services do not have a programmatic evaluation after the initial certification.

~~(6) OKDHS/ASD may authorize a legally responsible spouse or legal guardian of an adult member to be SoonerCare reimbursed under the 1915(c) ADvantage Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:~~

(6) OKDHS/ASD will not authorize a legal guardian for a member or an active Power of Attorney for a member to be that member's Consumer-Directed Personal Assistance Services and Supports (CD-PASS) provider of services.

(7) OKDHS/ASD may authorize a legally responsible spouse of a member to be SoonerCare reimbursed under the 1915 (c) ADvantage Program as a service provider.

(8) OKDHS/ASD may authorize a legal guardian of a member to be SoonerCare reimbursed under the 1915(c) ADvantage Program as a service provider except as a provider of CD-PASS services. Authorization for either spouse or legal guardian as a provider requires the following criteria and monitoring provisions to be met:

(A) Authorization for a spouse or legal guardian to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved waiver document;

(ii) be necessary to avoid institutionalization;

(iii) be a service/support that is specified in the individual service plan;

(iv) be provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;

(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency for the payment of personal care or personal assistance services;

(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

(i) not provide more than 40 hours of services in a seven day period;

(ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;

(iii) maintain and submit time sheets and other required documentation for hours paid; and

(iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA will monitor through documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and

(ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.

(9) Providers of durable medical equipment and supplies must comply with OAC 317:30-5-210(2) regarding proof of delivery for items shipped to the member's residence.

(~~7~~10) The OKDHS Aging Service Division (OKDHS/ASD) periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services)~~, Assisted Living Services,~~ and CD-PASS providers. If due to a programmatic audit, a provider Plan of Correction is required, the AA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OKDHS/ASD, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

**317:30-5-763. Description of services**

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in Oklahoma Department of Human Services/Aging Services Division (OKDHS/ASD) identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization

of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(3) **Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing,~~and/or~~ hair care or laundry is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing,~~and/or~~ hair ~~washing~~care or laundry will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing,~~and/or~~ hair ~~washing~~care or laundry to maintain health and safety.

(B) Adult Day Health Care is a 15-minute unit. No more than ~~6~~8 hours (32 units) are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing,~~and/or~~ hair ~~washing~~care or laundry service.

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the ~~Medicare rate, or~~ the SoonerCare rate if established, to the Medicare rate or to actual acquisition cost plus 30 percent. All services must be prior authorized.

(6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. ~~Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses.~~Nursing services may be provided on an intermittent or part time basis or may

be comprised of continuous care. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A ~~skilled~~ nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the ~~Skilled~~ Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The ADvantage Program case manager may recommend authorization of ~~Skilled~~ Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of ~~Skilled~~ Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development ~~skilled~~ nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of ~~skilled~~ nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled Nursing Services.**

(A) Skilled Nursing Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled Nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are for treatment of a disease or a medical condition and are beyond the scope of ADvantage Nursing Services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. It is the responsibility of the RN to contact the member's physician to

obtain any necessary information or orders pertaining to the care of the member. If the member has an ongoing need for service activities, which require more or less units than authorized, the RN shall recommend, in writing, that the Plan of Care be revised.

(B) Skilled Nursing services are provided on an intermittent or part-time basis, and billed in units of 15 minute increments. ADvantage Skilled Nursing services are provided when nursing services are not available through Medicare or other sources or when nursing services furnished under SoonerCare plan limits are exhausted. Amount, frequency and duration of services are prior authorized in accordance with member's service plan.

(~~8~~9) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(~~9~~10) **Occupational Therapy Services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~10~~11) **Physical Therapy Services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(~~11~~12) **Speech and Language Therapy Services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where

appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~12~~13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice care. ADvantage Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of ADvantage Hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's Hospice care within a twelve month period is limited to an amount equivalent to 85% of the Medicare Hospice Cap payment.

(~~13~~14) **ADvantage Personal Care.**

(A) ADvantage Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(~~14~~15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce

the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

(~~15~~16) **Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:

(i) recruits, hires and, as necessary, discharges the PSA or APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

(i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

(iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;

(ii) remove external catheters, inspect skin and reapplication of same;

(iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with members without contraindicating rectal or intestinal conditions;

(iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;

(v) use lift for transfers;

(vi) manually assist with oral medications;

(vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;

(viii) apply non-sterile dressings to superficial skin breaks or abrasions; and

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Financial Management Services are program administrative services provided to participating CD-PASS employer/members by the OKDHS/ASD. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

(v) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(~~16~~17) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage services but have been referred by the OKDHS/ASD to the Case Management Provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;

(iv) Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(D) If the member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services provided are not reimbursable.

(~~17~~18) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident

needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). The assisted living services provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the provision of assisted living services. ADvantage reimbursement for Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

(B) The ADvantage Assisted Living Services philosophy of service delivery promotes service member choice, and to the greatest extent possible, service member control. Members have control over their living space and choice of personal amenities, furnishing and activities in their residence. The Assisted Living Service provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery that emphasizes member dignity, privacy, individuality, and independence.

(C) ADvantage Assisted Living required policies for Admission/Termination of services and definitions.

(i) ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:

(I) unit availability;

(II) the compatibility of the participant with other residents; and

(III) the center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage participants.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate individuals who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member's designated representative and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy and dignity. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage participant's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living center services in the Oklahoma State Department of Health regulations (OAC 310:663-3-3) except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

(I) Provide an emergency call system for each participating ADvantage member;

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members' needs and choices; and

(III) Arrange or coordinate transportation to and from medical appointments.

(vi) The provider may offer any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the facility intends to market.

(vii) If the provider arranges and coordinates services for members, the provider is obligated to assure the provision of those services.

(viii) Under OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person". For ADvantage Assisted Living Services, assistance with "other personal needs" in this definition includes assistance with toileting, grooming and transferring and the term "assistance" is clarified to mean hands-on help in addition to supervision.

(ix) The specific Assisted Living Services assistance provided along with amount and duration of each type of assistance is based upon the individual member's assessed need for service assistance and is specified in the ALC's service plan which is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage Case Manager in cooperation with the Assisted Living Center professional staff develops the service plan to meet member needs. As

member needs change, the service plan is amended consistent with the assessed, documented need for change in services.

(x) Definition of Inappropriate ALC Placement. Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs;

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the ALC has documented efforts to resolve behavior problems including medical interventions, behavioral interventions and increased staffing interventions. Documentation must support that ALC attempted interventions to resolve behavior problems;

(III) The member has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. Documentation must support that ALC attempted to obtain appropriate care for the member; or

(IV) The member fails to pay room and board charges and/or the OKDHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC must develop a discharge plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the date of the notice;

(III) the date notice was given to the member and the member's representative;

(IV) the date by which the member must leave the ALC; and

(V) notification of appeal rights and process for submitting appeal of termination of Medicaid Assisted Living services to the OHCA.

(D) ADvantage Assisted Living Services provider standards in addition to licensure standards.

(i) Physical environment

(I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(III) For ALCS built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 360 square feet.

(IV) The ALC shall provide a private bathroom for each living unit which must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

(V) The ALC must provide at a minimum a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable), and adequate storage space for utensils.

(VI) The member is responsible for furnishing their rental unit. If a member is unable

to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the member's Case Manager in coordination with the ALC must assist the member in obtaining basic furnishings for the unit.

(VII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, the state and local sanitary codes, state building and fire safety codes and laws and regulations governing use and access by persons with disabilities.

(VIII) The ALC must ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A).

(IX) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(X) The ALC must provide appropriately monitored outdoor space for resident use.

(ii) Sanitation

(I) The ALC must maintain the facility, including its individual units, that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair and in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member units that maintains a safe, clean and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) Health and Safety

(I) The ALC must provide building security that protects residents from intruders with security measures appropriate to building design, environment risk factors and the resident population.

(II) The ALC must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths.

(III) The ALC must have a plan in place to prevent, contain and report any diseases that are considered to be infectious and/or are listed as diseases that must be reported to the Oklahoma State Department of Health.

(IV) The ALC must adopt policies for prevention of abuse, neglect and exploitation that include screening, training, prevention, investigation, protection during investigation and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of resident to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure that staff are trained to respond appropriately to emergencies.

(VII) The ALC staff must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for residents.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals;

(X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social/recreational outings.

(iv) Staff to resident ratios

(I) The ALC must ensure that a sufficient number of trained staff be on duty, awake, and present at all times, 24 hours a day, seven days a week, to meet the needs of residents and to carry out all the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other natural disasters.

(II) The ALC must ensure that staffing is sufficient to meet the needs of the ADvantage Program residents in accordance with each individual's ADvantage Service Plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications

(I) The ALC must ensure that all staff have qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health;

(III) The ALC must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of their employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must receive four additional hours of dementia specific training.

Annual first aid and CPR certification do not count towards the four hours of annual training.

(vi) Staff supervision

(I) The ALC must ensure delegation of tasks to non-licensed staff must be consistent and in compliance with all applicable State regulations including, but not limited to, the Oklahoma Nurse Practice Act and the OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors the member's health and nutritional status.

(vii) Resident rights

(I) The ALC must provide to each member and member's representative, at the time of admission, a copy of the resident statutory rights listed in O.S. 63-1-1918 amended to include additional rights and clarification of rights as listed in the ADvantage Consumer Assurances. A copy of the resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that its staff is familiar with, and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees and visitors, the assisted living center's complaint procedures and the name, address and telephone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. The ALC must ensure that all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance/appeal rights including a description of the process for submitting a grievance/appeal of any decision that decreases Medicaid services to the member.

(viii) Incident reporting

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage Case Manager, to the ADvantage Program AA and to other entities as required by law or regulation.

(II) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of Health (OSDH) in OAC 310:663-19-1.

(III) Reports of incidents must be made to the member's ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or the local municipal police department or sheriff's department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.

(V) The preliminary incident report must at the minimum include who, what, when and where and the measures taken to protect the resident(s) during the investigation. The follow-up report must at the minimum include preliminary information, the extent of the injury or damage, if any, and preliminary findings of the investigation. The final report at the minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings; and corrective measures to prevent future occurrences. If necessary to omit items, the final report must include why items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

(II) The ALC must provide or coordinate with the member and the member's ADvantage Case Manager for delivery of necessary health services. The ADvantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the service plan are provided in an appropriate and timely manner.

(E) Assisted Living Services are billed per diem of service for days covered by the ADvantage member's service plan and during which the Assisted Living Services provider is responsible for providing Assisted Living serviced as needed by the member. The

per diem rate for the ADvantage assisted living services for a member will be one of three per diem rate levels based upon individual member's need for service - type intensity and frequency to address member ADL/IADL and health care needs. The rate level is based upon UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider.

**317:30-5-763.1. Medicaid agency monitoring of the ADvantage program**

~~The OHCA will monitor the eligibility process and the ADvantage plan of care approval process by reviewing annually a minimum of three percent of ADvantage member service plans and associated member eligibility documents for members selected at random from the total number of members having new, reassessed or closed plans during the most recent 12 month audit period.~~

(~~1~~a) The OHCA's monitoring of the ADvantage Program is a quality assurance activity. ~~The monitoring evaluates whether program medical and financial eligibility determinations and plans of care authorizations have been done in accordance with OHCA policy and requirements specified in the approved waiver document.~~The agency evaluates the ADvantage program on a continual basis to ensure quality, through the review of various performance measures set forth in the waiver document. The areas evaluated include:

(1~~A~~) Member eligibility determination;

(2~~B~~) Member "freedom of choice";

(3) Member health and welfare;

(4~~C~~) ADvantage certified and SoonerCare contracted providers on the plan;

(5~~D~~) Member acceptance of the plan;

(6~~E~~) Qualified case managers;

(7~~F~~) Plan services are goal-oriented services; and,

(8~~G~~) Plan of care costs are within cost cap guidelines.

~~(2) At the discretion of the OHCA, the random selection of members for audit shall be done by the MMIS or the AA Waiver Management Information System using an algorithm approved by the OHCA.~~

~~(3) At the discretion of the OHCA, the OHCA auditor may review records at the AA place of business or have the AA mail or transport copied file documents to the OHCA place of business.~~

(~~4~~b) ~~Missing documents and/or deficiencies~~Deficiencies found by the OHCA are reported to the AA for correction and/or explanation. ~~Periodic reports of deficiencies are provided to the AA.~~Additionally, a quality management report is submitted to the Centers for Medicare and Medicaid Services annually.

**317:30-5-764. Reimbursement**

(a) Rates for waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for routine level of care nursing facility services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;

(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The PSA and APSA service unit rates are calculated by the OKDHS/ASD during the CD-PASS service eligibility determination process. The OKDHS/ASD sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need. The OKDHS/ASD, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member,

with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member ADL/IADL and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 ~~of~~times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 ~~of~~times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 ~~of~~times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider. ADvantage payment is not made for 24-hour skilled care in an Assisted Living Center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day care or environmental modifications to a member while receiving Assisted Living Services since these services are integral to and inherent in the provision of Assisted Living Service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage Assisted Living. Separate payment is not made for ADvantage respite to a member while receiving Assisted Living Services since by definition Assisted Living Services assume the responsibility for 24-hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage Assisted Living Services provider is allowed to charge a maximum for room and board that is no more than 90% of the SSI Federal Benefit Rate. If in accordance with OAC 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(7) The maximum total annual reimbursement for a member's Hospice care within a twelve month period is limited to an amount equivalent to 85% of the Medicare Hospice Cap payment.

(b) The OKDHS/ASD approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) Service time for Personal Care, Case Management, Case Management services for Institution Transitioning, Nursing, Skilled Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance is documented solely through the use of the Interactive Voice Response Authentication (IVRA) system when services are provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provisions will be turned over to ~~SURS~~the Program Integrity Unit for follow-up investigation.

*[OAR Docket #13-860; filed 5-21-13]*

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

*[OAR Docket #13-834]*

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 113. Living Choice Program
317:30-5-1200. [AMENDED]
317:30-5-1202. [AMENDED]
317:30-5-1203. [AMENDED]
**(Reference APA WF # 12-05)**

**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes; Section 6071 of the Deficit Reduction Act of 2005

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**ANALYSIS:**
OHCA rules for the Living Choice demonstration program are revised to include clarification for the billing of Institutional Case Management Transition services and the inclusion of additional services for persons with physical disabilities and long term illnesses. Additional services added are Assisted Living Services and Private Duty Nursing. Assisted Living Services are services such as personal care and other supportive services furnished to members in an OHCA certified assisted living center. Rules are also revised to add an option for self-direction. Self-direction allows members, as the employer of record, to hire individual providers for Personal Care services, Advanced Supportive/Restorative services and Respite services.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 113. LIVING CHOICE PROGRAM

### 317:30-5-1200. Benefits for members age 65 or older with disabilities or long-term illnesses

(a) Living Choice program participants age 65 or older with disabilities or long-term illnesses may receive a range of necessary medical and home and community based services for one year after moving from an institutional setting. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.
(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.
(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.
(d) Services that may be provided through the Living Choice program for older persons with disabilities or long-term illnesses are listed in paragraphs (1) through ~~(24)~~(26) of this subsection:
(1) case management;
(2) respite care;
(3) adult day health care;
(4) environmental modifications;
(5) specialized medical equipment and supplies;
(6) therapy services including physical, occupational, speech and respiratory;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) extended duty nursing;
(~~9~~10) home delivered meals;
(~~10~~11) hospice care;
(~~11~~12) medically necessary prescription drugs;
(~~12~~13) personal care as described in Part 95 of this Chapter;
(~~13~~14) Personal Emergency Response System (PERS);
~~(14) Consumer Directed Personal Assistance Services and Supports (CD-PASS)~~
(15) self-direction;
(~~15~~16) transition coordination;
(~~16~~17) community transition services as described in OAC 317:30-5-1205;
(~~17~~18) dental services (up to $1,000 per person annually);
(~~18~~19) nutrition evaluation and education services;
(~~19~~20) agency companion services;
(~~20~~21) pharmacological evaluations;
(~~21~~22) vision services including eye examinations and eyeglasses;
(~~22~~23) non-emergency transportation;
(~~23~~24) family training services; ~~and~~
(25) assisted living services; and
(~~24~~26) SoonerCare compensable medical services.

### 317:30-5-1202. Benefits for members with physical disabilities

(a) Living Choice program participants with physical disabilities may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.
(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.
(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.
(d) Services that may be provided to members with physical disabilities are listed in paragraphs (1) through ~~(31)~~(32) of this subsection:
(1) case management;
(2) personal care services as described in Part 95 of this Chapter;
(3) respite care;
(4) adult day health care with personal care and therapy enhancements;
(5) architectural modifications;
(6) specialized medical equipment and supplies;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) home delivered meals;

(10) therapy services including physical, occupational, speech and respiratory;
(11) hospice care;
(12) Personal Emergency Response System (PERS);
(13) ~~Consumer-Directed Personal Assistance Services (CD-PASS)~~Self-Direction;
(14) agency companion services;
(15) extended duty nursing;
(16) psychological services;
(17) audiology treatment and evaluation;
(18) non-emergency transportation;
(19) assistive technology;
(20) dental services (up to $1,000 per person annually);
(21) vision services including eye examinations and eyeglasses;
(22) pharmacotherapy management;
(23) independent living skills training;
(24) nutrition services;
(25) family counseling;
(26) family training;
(27) transition coordination;
(28) psychiatry services;
(29) community transition services as described in OAC 317:30-5-1205;
(30) pharmacological evaluations; ~~and~~
(31) assisted living services; and
(~~31~~32) SoonerCare compensable medical services.

**317:30-5-1203. Billing procedures for Living Choice services**

(a) The approved individual transition plan is the medical basis for services and includes the prior authorizations, specifying:
(1) ~~what~~the service;
(2) ~~which~~the service provider;
(3) the number of units authorized; and
(4) the authorized begin and end dates of the service.

(b) Institution Transition Case Management services are billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served. A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services. The services are billed effective the date of transition into Living Choice and the provider records document actual time and date of services provided.

(~~b~~c) As part of Living Choice quality assurance, audits are used to evaluate whether claims are consistent with individual transition plans and services provided are documented. Claims that are not supported by individual transition plans and/or documentation of services are referred to the ~~Surveillance Utilization Review Subsystem unit (SURS)~~Program Integrity unit. Erroneous or invalidated claims identified through post payment reviews are recouped from the provider.

(~~c~~d) Claims may not be filed until the services are rendered.

*[OAR Docket #13-834; filed 5-21-13]*

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

*[OAR Docket #13-863]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care ~~Facilities~~Facilities
317:30-5-131.1.[AMENDED]
317:30-5-131.2.[AMENDED]
317:30-5-132.[AMENDED]
317:30-5-133.[AMENDED]
**(Reference APA WF # 12-43)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Sections 5003 through 5016 and Section 5022 of Title 63 of the Oklahoma Statutes; Nursing Home Care Act, Section 1-1925.2 of Title 63 of the Oklahoma Statutes; Fees - Oklahoma Health Care Authority, Section 2002 of Title 56 of the Oklahoma Statutes; Medicaid State Plan as approved by the Centers for Medicare and Medicaid Services (CMS)
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**ANALYSIS:**
The proposed rule change adds language clarifying that all program requirements set out in State Statute and Oklahoma Health Care Authority policy regarding wage enhancements for certain nursing facility employees have been met. The proposed rule change also clarifies that the Quality of Care fee assessed by the Oklahoma Health Care Authority is authorized through the Medicaid State Plan and clarifies that part of the fee structure is based on a waiver of uniformity as approved by the Centers for Medicare and Medicaid Services (CMS). Finally, proposed revisions include the removal of language incorrectly stating that rates for public ICF's/MR are set through a public rate setting process rather than the current practice of reimbursement based on cost reports. Other minor policy clarifications are also included as a part of the proposed rule change.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 9. LONG TERM CARE ~~FACILIIES~~FACILITIES

**317:30-5-131.1. Wage enhancement**

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

(1) **"Employee Benefits"** means the benefits an employer provides to an employee which include:

(A) FICA taxes,

(B) Unemployment Compensation Tax,

(C) Worker's Compensation Insurance,

(D) Group health and dental insurance,

(E) Retirement and pensions, and

(F) Other employee benefits (any other benefit that is provided by a majority of the industry).

(2) **"Enhanced"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statutes.

(3) **"Enhancement"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statute.

(4) **"Regular employee"** means an employee that is paid an hourly/salaried amount for services rendered, however, the facility is not excluded from paying employee benefits.

(5) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022, Title 63 that meet the requirements listed in 42 CFR Section 483.75(e)(1)-(8).

(b) **Enhancement.** Effective May 1, 1997, the OHCA provides a wage and salary enhancement to nursing facilities serving adults and Intermediate Care Facilities for ~~the Mentally Retarded~~ Individuals with Intellectual Disabilities required by Title 63, Section 5022 of Oklahoma Statutes. The purpose of the wage and salary enhancement is to provide an adjustment to the facility payment rate in order for facilities to reduce turnover and be able to attract and retain qualified personnel. The maximum wage enhancement rates that may be reimbursed to the facilities per diem include:

(1) Three dollars and fifteen cents ($3.15) per patient day for NFs,

(2) Four dollars and twenty cents ($4.20) per patient day for standard private ~~ICFs/MR~~ ICFs/IID, and

(3) Five dollars and fifteen cents ($5.15) per patient day for specialized private ~~ICFs/MR~~ ICFs/IID.

(c) **Reporting requirements.** Each NF and ~~ICF/MR~~ICF/IID is required to submit a Nursing and Intermediate Care Facilities Quarterly Wage Enhancement Report (QER) which captures and calculates specified facility expenses. The report must be completed quarterly and returned to OHCA no later than 45 days following the end of each quarter. QERs must be filed for the State Fiscal Year (SFY) which runs from July 1 to June 30. The Oklahoma Health Care Authority reserves the right to recoup all dollars that cannot be accounted for in the absence of a report. The QER is designed to capture and calculate specified facility expenses for quarterly auditing by the OHCA. The report is used to determine whether wage enhancement payments are being distributed among salaries/wages, employee benefits, or both for the employee positions listed in (1) through (8) of this subsection. Furthermore, the OHCA reserves the right to recoup all dollars not spent on salaries, wages, employee benefits, or both for the employee positions. The specified employee positions included on the QER are:

(1) Licensed Practical Nurse (LPN),

(2) Nurse Aide (NA),

(3) Certified Medication Aide (CMA),

(4) Social Service Director (SSD),

(5) Other Social Service Staff (OSSS),

(6) Activities Director (AD),

(7) Other Activities Staff (OAS), and

(8) Therapy Aide Assistant (TAA).

(d) **Timely filing and extension of time.**

(1) **Quarterly reports.** Quarterly reports are required to be filed within 45 days following the end of each quarter. This requirement is rigidly enforced unless approved extensions of time for the filing of the quarterly report is granted by OHCA. Filing extensions not to exceed 15 calendar days may be granted for extraordinary cause only. A failure to present any of the items listed in (A)-(D) of this paragraph will result in a denial of the request for an extension. The extension request will be attached to the filing of the report after the request has been granted. For an extension to be granted, the following must occur.

(A) An extension request must be received at the Oklahoma Health Care Authority on or before the 30th day after the end of the quarter.

(B) The extension must be addressed on a form supplied by the Health Care Authority.

(C) The facility must demonstrate there is an extraordinary reason for the need to have an extension. An extraordinary reason is defined in the plain meaning of the word. Therefore, it does not include reasons such as the employee who normally makes these requests was absent, someone at the facility made a mistake and forgot to send the form, the facility failed to get documents to some third party to evaluate the expenditures. An unusual and unforeseen event must be the reason for the extension request.

(D) The facility must not have any extension request granted for a period of two years prior to the current request.

(2) **Failure to file a quarterly report.** If the facility fails to file the quarterly report within the required (or extended) time, the facility is treated as out of compliance and payments made for the quarter in which no report was filed will be subject to a 100% recoupment. The overpayment is recouped in future payments to the facility immediately following the filing deadline for the reporting period. The full overpayment is recovered within a three month period. The Oklahoma Health Care Authority reserves the right to discontinue wage enhancement payments until an acceptable QER (quarterly enhancement

report) is received. In addition to the recoupment of payments, the matter of noncompliance is referred to the Legal Division of the OHCA to be considered in connection with the renewal of the facility's contract.

(3) **Ownership changes and fractional quarter report.** Where the ownership or operation of a facility changes hands during the quarter, or where a new operation is commenced, a fractional quarter report is required, covering each period of time the facility was in operation during the quarter.

(A) Fractional quarter reports are linked to the legal requirement that all facility reports be properly filed in order that the overall cost of operation of the facility may be determined.

(B) Upon notice of any change in ownership or management, the OHCA withholds payments from the facility until a fractional quarter report is received and evaluation of payment for the wage enhancement is conducted. In this case the QER is due within 15 days of the ownership or management change.

(4) **Pay periods and employee benefits reflected in the QER.** Salaries and wages are determined by accruing the payroll to reflect the number of days reported for the month. Unpaid salaries and wages are accrued through the quarter. Any salaries and wages accrued in the previous quarter and paid in the current quarter are excluded. Employee benefits are determined by accruing any benefits paid to coincide with the reporting month. Unpaid employee benefits are accrued through the quarter. Any employee benefits accrued in the previous quarter and paid in the current quarter are excluded. To be included as an allowable wage enhancement expenditure, accrued salaries, wages and benefits must be paid within forty-five (45) days from the end of the reporting quarter.

(5) **Report accuracy.** Errors and/or omissions discovered by the provider after the initial filing/approved extension are not considered grounds for re-opening/revisions of previously filed reports. Furthermore, errors and/or omission discovered by the provider after the initial filing/approved extension can not be carried forward and claimed for future quarterly reporting periods.

(6) **False statements or misrepresentations.** Penalties for false statements or misrepresentations made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, *"(a) Whoever...(2) at any time knowingly and willfully makes or cause to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. §1320 et. seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."*

(7) **Audits, desk and site reviews.**

(A) Upon receipt of each quarterly report a desk review is performed. During this process, the report is examined to insure it is complete. If any required information is deemed to have been omitted, the report may be returned for completion. Delays that are due to incomplete reports are counted toward the 45 day deadline outlined in (c) of this Section. At that time the mathematical accuracy of all totals and extensions is verified. Census information may be independently verified through other sources. After completion of the desk review, each report is entered into the OHCA's computerized data base. This facilitates the overall evaluation of the industry's costs.

(B) Announced and/or unannounced site reviews are conducted at a time designated by the OHCA. The purpose of site reviews is to verify the information reported on the QER(s) submitted by the facility to the OHCA. Errors and/or omissions discovered by the OHCA upon the completion of a site review is immediately reflected in future payment(s) to the facility. The OHCA makes deficiencies known to the facility within 30 calendar days. A deficiency notice in no way prevents the OHCA from additionally finding any overpayment and adjusting future payments to reflect these findings.

(8) **Appeals process.**

(A) If the desk or site review indicates that a facility has been improperly paid, the OHCA will notify the facility that the OHCA will rectify the improper payment in future payments to the facility. Improper payments consist of an overpayment to a facility. The facility may appeal the determination to recoup an alleged overpayment and/or the size of the alleged overpayment, within 20 days of receipt of notice of the improper payment from the OHCA. Such appeals will be Level I proceedings heard pursuant to OAC 317:2-1-2(c)(2). The issues on appeals will be limited to whether an improper payment occurred and the size of the alleged improper payment. The methodology for determining base period computations will not be an issue considered by the administrative law judge.

(B) Certain exceptional circumstances, such as material expenses due to the use of contract employees, overtime expenses paid to direct care staff, or changes within classes of staff may have an effect on the wage enhancement payment and expense results. Facilities may demonstrate and present documentation of the affects of such circumstances before the administrative law judge.

(e) **Methodology for the distribution of payments/adjustments.** The OHCA initiates a two-part process for the distribution and/or recoupment of the wage enhancement.

(1) **Distribution of wage enhancement revenue.** All wage enhancement rates are added to the current facility

per diem rate. Facilities receive the maximum wage enhancement rate applicable to each facility type.

(2) **Payment/recoupment of adjustment process.** Initially, all overpayments resulting from the Fourth Quarter of SFY-1997 and the First Quarter of SFY-1998 audits will be deducted from the first month's payment of the Third Quarter of SFY-1998 (January-1998). The Fourth and First Quarter of SFY-1997 and SFY 1998 audit results will be averaged to determine the adjustment. All overpayments as a result of the Second Quarter of SFY-1998 audit will be deducted from the first month's payment of the Fourth Quarter of SFY-1998 (April-1998). Audit results will determine whether or not a facility is utilizing wage enhancement payments that are being added to the facility's per diem rate. When audit results for a given quarter after the Second Quarter of SFY-1998 (October, November, and December 1997) reflect an adjustment, recoupments will be deducted from the facility. Any adjustments calculated will not be recouped during the quarter in which the calculation is made, rather, they will be recouped during the following quarter. The recoupments, as a result of an adjustment, will not exceed the wage enhancement revenue received for the quarter in which the audit is conducted. Recoupments will be included in the facility's monthly payment and will not exceed the three month period of the quarter in which it is being recouped.

(f) **Methodology for determining base year cost.** The information used to calculate Base Year Cost is taken from actual SFY-1995 cost reports submitted, to the OHCA, by the NFs and ICFs/MR that will be receiving a wage enhancement. A Statewide Average Base Cost is calculated for facilities that did not submit a cost report for SFY-1995. Newly constructed facilities that submit a partial year report are assigned the lower of the Statewide Average Base Cost or actual cost. The process for calculating the Base Year Cost, the Statewide Average Base Cost, and the process for newly constructed facilities is determined as follows.

(1) **Methodology used for determining base year cost.** The methodology for determining the Base Year Cost is determined by the steps listed in (A) through (E) of this paragraph.

(A) Regular employee salaries are determined by adding the salaries of LPNs, NAs, CMAs, SSDs, OSSS, ADs, OAS, and TAAs.

(B) Percentage of benefits allowed are determined by dividing total facility benefits by total facility salaries and wages.

(C) Total expenditures are determined by multiplying the sum of regular employee salaries by a factor of one plus the percentage of benefits allowed in (B) of this subparagraph.

(D) Base Year PPD Costs are determined by dividing total expenditures, in (3) of this subparagraph by total facility patient days. This information is used to determine statewide average base year cost.

(E) Inflated Base Year Costs are determined by multiplying Base Year Cost, in (C) of this subparagraph by the appropriate inflation factors. Base Year Expenditures were adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(2) **Methodology used for determining Statewide Average Base Cost.** A Statewide Average Base Cost is calculated for all facilities that did not submit a cost report, to the OHCA, for SFY-1995. The steps listed in (A) through (C) of this paragraph are applied to determine the Base Cost in the absence of actual SFY-1995 cost report information.

(A) Statewide Average Base Year PPD Costs are determined by adding Base Year PPD Cost, calculated in (1)(D) of this subsection, for all facilities that submitted SFY-1995 cost reports, the sum of this calculation is then divided by the number of facilities that submitted cost reports.

(B) Inflated Base Year PPD Costs are determined by multiplying Statewide Base Year PPD Cost by the appropriate inflation factors. Statewide Base Year PPD Cost was adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(C) The facilities base cost is determined by multiplying the facilities' current quarter census by the inflated statewide average PPD costs calculated in (B) of this unit.

(g) **Methodology for determining wage enhancement revenue and expenditure results.** The methodology for determining the facilities' wage enhancement revenue and expenditures results are calculated in (1) through (3) of this paragraph.

(1) **Wage enhancement revenue.** Total wage enhancement revenue received by the facility for the current quarter is calculated by multiplying the facilities total paid Medicaid days for the current quarter by the facilities wage enhancement rate. The Oklahoma Health Care Authority adjusts the computations and results when actual paid Medicaid data for the reporting quarter becomes available.

(2) **Wage enhancement expenditures.** Total wage enhancement expenditures are determined in a four step process as described in (A) through (D) of this paragraph.

(A) Total current quarter allowable expenses are calculated. Salaries and wages of specified staff are

totaled and added to the applicable percent of customary employee benefits and 100% of the new employee benefits.

(B) Base period expenditures are calculated. An occupancy adjustment factor is applied to the quarterly average base period cost to account for changes in census.

(C) Current quarter wage enhancement expenditures are calculated by subtracting allowable base period expenditures (see (B) of this subparagraph) from total current quarter allowable expenses (see (A) of this subparagraph).

(D) Total wage enhancement expenditures are calculated by adding current quarter wage enhancement expenditures (see (C) of this subparagraph) to prior period wage enhancement expenditures carried forward.

(3) **Wage enhancement revenue and expenditure results.** Wage enhancement revenue and expenditure results are determined by comparing total wage enhancement revenue (see (1) of this paragraph) to total wage enhancement expenditures (see (2)(D) of this paragraph). Revenue exceeding expenses is subject to recoupment. Expenses exceeding revenue are carried forward to the next reporting period as a prior period wage enhancement expenditure carry over.

(4) Due to rate increases and increases in the federal minimum wage, wage enhancements to nursing facilities and ICFs/MR are no longer paid.

**317:30-5-131.2. Quality of care fund requirements and report**

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise:

(1) **"Nursing Facility and Intermediate Care Facility for ~~the mentally retarded~~ Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities licensed in this State.

(3) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities licensed in the State.

(5) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

(8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for ~~the mentally retarded~~ individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statues, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(9) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(10) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.

(11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.

(12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(14) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(b) **Quality of care fund assessments.**

(1) The Oklahoma Health Care Authority (OHCA) was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of the fee to be assessed for the period of

10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above. As per 56 O.S. Section ~~202~~2002, as amended, the fees are frozen at the amount in effect at July 1, 2004. Also, the fee will be monitored to never surpass the federal maximum ~~of 5.5%~~.

(4) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services (CMS) regarding waiver of uniformity requirements related to the fee.

(~~4~~5) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(~~5~~6) The method of collection is as follows:

(A) The Oklahoma Health Care Authority assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The Oklahoma Health Care Authority notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the Oklahoma Health Care Authority by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the Authority the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for Oklahoma Health Care Authority Cost Reporting purposes.

(E) The Quality of Care fund which contains assessments collected excluding penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) Effective September 1, 2000, all nursing facilities and intermediate care facilities for ~~the mentally retarded (ICFs/MR)~~individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse
(B) Licensed Practical Nurse
(C) Nurse Aide
(D) Certified Medication Aide
(E) Qualified ~~Mental Retardation~~Intellectual Disability Professional ~~(ICFs/MR only)~~ (ICFs/IID only)
(F) Physical Therapist
(G) Occupational Therapist
(H) Respiratory Therapist
(I) Speech Therapist
(J) Therapy Aide/Assistant
(K) Social Services Director/Social Worker
(L) Other Social Services Staff
(M) Activities Director
(N) Other Activities Staff
(O) Combined Social Services/Activities

(3) Prior to September 1, 2003, activity and social services staff who did not provide direct, hands-on care may be included in the direct-care-staff-to-resident ratio in any shift or direct-care service rates. On and after September 1, 2003, such persons are not included in the direct-care-staff-to-resident ratio or direct-care service rates.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for ~~the mentally retarded~~individuals with intellectual disabilities must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.** Effective November 1, 2000, all nursing facilities and private intermediate care facilities for ~~the mentally retarded~~individuals with intellectual disabilities receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of $6.65 per hour.

Employee positions included for purposes of minimum wage for specified staff are as follows:

(1) Registered Nurse
(2) Licensed Practical Nurse
(3) Nurse Aide
(4) Certified Medication Aide
(5) Other Social Service Staff
(6) Other Activities Staff
(7) Combined Social Services/Activities
(8) Other Dietary Staff
(9) Housekeeping Supervisor and Staff
(10) Maintenance Supervisor and Staff
(11) Laundry Supervisor and Staff

(e) **Quality of care reports.** Effective September 1, 2000, all nursing facilities and intermediate care facilities for ~~the mentally retarded~~ individuals with intellectual disabilities must submit a monthly report developed by the Oklahoma Health Care Authority, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "*Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment...shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.*"

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report either through electronic mail to the Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit written notification with adequate, objective and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the Oklahoma Health Care Authority.

(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the Authority notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; available bed days; Medicare bed days; Medicaid bed days; and total gross receipts.

(10) Audits may be performed to determine compliance pursuant to subsections (b), (c) and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the Oklahoma State Department of Health for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The Oklahoma State Department of Health informs the Oklahoma Health Care Authority of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that

does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH) to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.

**317:30-5-132. Cost reports**

Each Medicaid-participating long term care facility is required to submit an annual uniform cost report, designed by OHCA, for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before the last day of October of the subsequent year.

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

(2) The cost report must be filed using the Secure Website. The instructions and data entry screen simulations will be made available on the OHCA public website under the Provider/Long Term Care Facility/Cost Reporting options.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation. These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the secure website system) to the Finance Division of the OHCA on the forms and by the instructions found on the OHCA public website (see directions as noted above).

(4) Cost report instructions ~~are mailed annually to each facility before the first of July and~~ are available on the public website at OKHCA.org/Provider/Opportunitiesforliving life/longtermcarefacilities.

(5) Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaid-covered expense which nursing facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, dental examinations, dentures and related services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside the nursing facility rate are not included in the cost report and are not allowable costs.

(6) All reports are subject to on-site audits and are deemed public records.

**317:30-5-133. Payment methodologies**

(a) **Private Nursing Facilities.**

(1) **Facilities.** Private Nursing Facilities include:

(A) Nursing Facilities serving adults (NF),

(B) Nursing Facilities serving Aids Patients (NF-Aids),

(C) Nursing Facilities serving Ventilator Patients (NF-Vents),

(D) Intermediate Care Facilities for ~~the Mentally Retarded (ICF/MR)~~Individuals with Intellectual Disabilities (ICF/IID),

(E) Intermediate Care Facilities with 16 beds or less serving Severely or Profoundly ~~Retarded~~intellectually disabled Patients (Acute ~~ICF/MR~~ICF/IID), and

(F) Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State MR Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASRR/MR Level II screen. The per diem add-on is calculated as the difference in the statewide standard private MR base rate and the statewide NF facility base rate.

(2) **Reimbursement calculations.** Rates for Private Nursing Facilities will be reviewed periodically and adjusted as necessary through a public process. Payment will be made to Private Nursing Facilities pursuant to the methodology described in the Oklahoma Title XIX State Plan.

(b) **Public Nursing Facilities.** Reimbursement for public Intermediate Care Facilities for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities~~(ICF/MR)~~(ICFs/IID) shall be based on each facility's reasonable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement as set forth in the provider reimbursement manual. ~~Rates for~~

~~Public facilities will be reviewed periodically and adjusted as necessary through a public process.~~

*[OAR Docket #13-863; filed 5-21-13]*

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

*[OAR Docket #13-843]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95.25. [AMENDED]
317:30-5-95.29. [AMENDED]
317:30-5-95.33. through 317:30-5-95.35. [AMENDED]
317:30-5-95.37. [AMENDED]
317:30-5-95.41. [AMENDED]
317:30-5-95.42. [AMENDED]
**(Reference APA WF # 12-40)**
**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 441.154 through 441.156
**DATES:**
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**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
**Final adoption:**
May 14, 2013
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
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N/A
**ANALYSIS:**
Agency Inpatient Psychiatric Hospital rules are being revised to clarify the medical necessity criteria required for admission and continued stays in psychiatric residential treatment facility (PRTF) and acute levels of care. Changes are also being proposed to the rules regarding Individual Plans of Care to ensure early parent/guardian involvement in the treatment of children under the age of 18 receiving inpatient psychiatric services as well as to revise the "active treatment" requirements for individuals 18-21 years of age receiving services in an acute psychiatric hospital by making the requirements less proscriptive for this age group since they typically do not receive services in children's psychiatric units, so these facilities should not be held to the same requirements. Active treatment requirements for children under 18 are further revised to provide more clarity in areas that have been identified as causing provider confusion. Proposed revisions will also revise Inspection of Care (IOC) rules to provide the pro-rating timeline used when reviewing clinical documentation for compliance with active treatment requirements as well as to clarify that certain "critical documents" cannot be substituted with other evaluations/assessments. Rules are also revised to make clean-up changes to certain provisions that are outdated or no longer applicable.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 6. INPATIENT PSYCHIATRIC HOSPITALS

### 317:30-5-95.25. Medical necessity criteria for acute psychiatric admissions for children

~~Acute psychiatric admissions for children 13 or older must meet the terms and conditions contained in (1), (2), (3), (4) and two of the terms and conditions in (5)(A) to (6)(C) of this subsection.~~ Acute psychiatric admissions for children ~~12 or younger~~ must meet the terms or conditions contained in (1), (2), (3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis of any personality disorder.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary Axis I diagnosis.

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.

(4) Child must be medically stable.

(5) Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicide intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

**317:30-5-95.29. Medical necessity criteria for admission - psychiatric residential treatment for children**

Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1)~~ to~~, (2), (3), (4), (6) and one of ~~the~~ (5)(A) through (5)(D)~~, and one of (6)(A) through (6)(C)~~ of this subsection.

(1) An Axis I primary diagnosis ~~form~~from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses).

(3) Patient has either received treatment in an acute care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.

(4) Child must be medically stable.

(5) Within the past 14 calendar days, the ~~Patient demonstrates~~patient has demonstrated an escalating pattern of ~~self-injurious~~self-injurious or assaultive behaviors as evidenced by~~:~~ any of (A) through (D) below. Exceptions to the 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 14 days (i.e. sexual offenses).

(A) Suicidal ideation and/or threat.

(B) History of or current self-injurious behavior.

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

(6) Requires 24-hour observation and treatment as evidenced by:

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

(C) Intensive treatment in preparation for re-entry into community.

**317:30-5-95.33. Individual plan of care for children**

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to an acute psychiatric facility or a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the member;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the member's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation

must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;

(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for members under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. <u>If the member's parent/guardian is unable to sign the IPC or IPC review on the date it is completed, then within 72 hours the Provider must in good faith and with due diligence attempt to telephonically notify the parent/guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/guardian must be included in the clinical file.</u> In those instances where it is necessary to <u>mail or</u> fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or photocopied signatures are not allowed for any parent or member of the treatment team.

**317:30-5-95.34. Active treatment for children**

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(2) **"Family therapy"** means interaction between a LBHP, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(3) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(4) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between a LBPH and a member to promote emotional or psychological change to alleviate disorders.

(6) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between a LBHP as defined in OAC 317:30-5-240.3, and two or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

<u>(c) For individuals age 18 up to 21, the Active Treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services</u>

and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face-to-face. Services, including type and frequency, will be specified in the Individual Plan of Care.

(~~c~~d) For individuals under age 18, ~~The~~the components of Active Treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Sixty minutes is the expectation to equal one hour of treatment. When appropriate to meet the needs of the child, the 60 minute timeframe may be split into sessions of no less than 15 minutes each on the condition that the Active Treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) Individual treatment provided by the physician. Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten calendar days between sessions in PRTFs, never exceed seven calendar days in a specialty PRTF and never exceed 30 calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(2) Individual therapy. LBHPs performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a LBHP as described in OAC ~~317:30-5-240.3~~317:30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(3) Family therapy. The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential treatment~~ for members under the age of 18~~. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by a LBHP as described in OAC 317:30-5-240.3.

(4) Process group therapy. The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by a LBHP as defined in OAC ~~317:30-5-240.3~~317:30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy may be substituted.

(5) Expressive group therapy. Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy. Expressive group therapy must be provided four hours per week in acute care, three hours per week in residential treatment and twice a week in CBT. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.

(6) Group ~~Rehabilitative~~rehabilitative treatment. Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care. Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care with the exception of CBT. Individuals in CBT must receive a total of 6 hours of ~~Group~~group rehabilitative treatment per week ~~in CBT must be~~ provided at a frequency of no less than 6 times a week. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.

(7) Individual rehabilitative treatment. Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis. One hour of individual rehabilitative treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.

(8) Modifications to active treatment. When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation

must demonstrate that alternative clinically appropriate services were provided.

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in Acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in RTC, PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components do not include assessments/evaluations. Active treatment begins the day of admission. Days noted are calendar days.

(1) Individual treatment provided by the physician.

(A) In acute, by day two, 1 visit is required. By day 4, 2 visits are required. By day 7, 3 visits are required.

(B) In RTC, PRTF or CBT, one visit during admission week is required. In RTCs, 1 visit during the admission week is required, then once a week thereafter. In PRTFs, one visit during the admission week is required, then once a week thereafter. In CBT, 1 visit is required within 7 days of admission. Individual treatment provided by the physician will never exceed 10 days between sessions in PRTFs, never exceed 7 days in a specialty PRTF and never exceed 30 days in CBTs. These visits do not include the Psychiatric Evaluation or History and Physical.

(2) Individual therapy.

(A) In acute, by day 3, 30 minutes of treatment are required. By day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week. This does not include admission assessments/evaluations or Psychosocial Evaluations.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessment/evaluation or Psychosocial Evaluations.

(3) Family therapy.

(A) In acute, by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessments/evaluation or Psychosocial Evaluations.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admissions assessment/evaluation or Psychosocial Evaluations.

(4) Process group therapy.

(A) In acute, by day 3, 1 hour of treatment is required. By day 5, 2 hours of treatment are required. Beginning day 7, 3 hours of treatment are required each week.

(B) In residential treatment (including PRTF and CBT) by day 5, 1 hour of treatment must be documented. Beginning on day 7, 2 hours of treatment are required each week.

(5) Expressive group therapy.

(A) In acute by day 2, 1 hour of treatment is required. By day 4, 2 hours of treatment are required. By day 6, 3 hours of treatment are required. Beginning day 7, 4 hours of treatment are required each week.

(B) In residential treatment (including PRTF) by day 3, 1 hour of treatment is required. By day 5, 2 hours of treatment are required. Beginning day 7, 3 hours of treatment are required each week.

(C) In CBT, by day 4, 1 hour of treatment is required. Beginning day 7, 2 hours of treatment are required each week.

(6) Rehabilitative treatment.

(A) In acute and RTC (including PRTF and specialty) on day 1, safety and unit orientation are required. Beginning day 2, 2 hours of Group Rehabilitation or 1 hour of Individual Rehabilitation is required.

(B) In CBT, by day 7, 6 hours of treatment are required.

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (RN/LPN), documentation must be in the record clearly indicating the reason and timeframe for those services to be excused without penalty.

**317:30-5-95.35. Credentialing requirements for treatment team members for children**

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(2) a behavioral health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner–; Licensed Alcohol and Drug Counselor (LADC), (or) Licensed Marital and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner, Licensed Alcohol and Drug Counselor and Psychology (health services specialty only) can provide individual therapy, family therapy and process group therapy as long as they are

involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team. All co-signatures by fully licensed LBHPs must be accompanied by the date that the co-signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully licensed LBHP.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not SoonerCare compensable and can not be billed to the SoonerCare member.

**317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children**

The member's medical record must contain complete medical, psychiatric and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within 48 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.

(B) Psychiatric evaluation must be completed within 60 hours of admission by a M.D. or D.O and within 7 calendar days in a CBT.

(C) Psychosocial evaluation must be completed within 72 hours of an acute admission~~.~~, within seven calendar days of admission to a PRTF and within 7 calendar days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) or a ~~mental health professional~~licensed behavioral health professional (LBHP) as defined in OAC ~~317:30-5-240.3~~317:30-5-240.3.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than 30 calendar days from admission. For continued stays at the same level of care, ~~Evaluations~~evaluations remain current for 12 months from the date of admission and must be updated annually within seven calendar days of that anniversary date.

(4) The history and physical evaluation, psychiatric evaluation and psychosocial evaluation must be completed within the time lines designated in this section or those days will be rendered non-compensable for SoonerCare until completed.

**317:30-5-95.41. Documentation of records for children's inpatient services**

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:

(1) date;

(2) start and stop time for each session;

(3) dated signature of the therapist and/or staff that provided the service;

(4) credentials of the therapist;

(5) specific problem(s) addressed (problems must be identified on the plan of care);

(6) method(s) used to address problems;

(7) progress made towards goals;

(8) member's response to the session or intervention; and

(9) any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan of care reviews.

**317:30-5-95.42. Inspection of care of psychiatric facilities providing services to children**

(a) There will be an on site Inspection of Care (IOC) of each psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. The Oklahoma Health Care Authority will designate the members of the Inspection of Care team.

(b) The IOC team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.

(c) The inspection will include observation and contact with members. The Inspection of Care Review will consist of members present or listed as facility residents at the beginning of the Inspection of Care visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.

(d) Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The facility will be provided with written notification if the findings of the inspection of care have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.

(e) Deficiencies found during the IOC may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment~~ and~~, must be completed within the time lines designated in OAC

317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:

(1) History and physical evaluation;
(2) Psychiatric evaluation;
(3) Psychosocial evaluation; and
(4) Individual Plan of Care.

(f) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and Individual Plan of Care are not contained within the member's records, those days will warrant a full per-diem recoupment of the compensation received. Full per-diem recoupment will only occur for those documents.

(g) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.

(h) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

*[OAR Docket #13-843; filed 5-21-13]*

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

*[OAR Docket #13-861]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
317:35-1-1. [AMENDED]
317:35-1-2. [AMENDED]
317:35-1-3. [AMENDED]
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-1. [AMENDED]
317:35-5-2. [AMENDED]
317:35-5-6. [AMENDED]
317:35-5-6.1. [AMENDED]
317:35-5-7. [AMENDED]
317:35-5-8. [AMENDED]
Part 5. Countable Income and Resources
317:35-5-43. [AMENDED]
317:35-5-44. [AMENDED]
317:35-5-45. [AMENDED]
317:35-5-46. [AMENDED]
Part 7. Application and Eligibility Determination Procedures [NEW]
317:35-5-60. [NEW]
317:35-5-61. [RESERVED]
317:35-5-62. [RESERVED]
317:35-5-63. [NEW]
317:35-5-64. [NEW]
Subchapter 6. SoonerCare for Pregnant Women and Families with Children
Part 1. General
317:35-6-1. [AMENDED]
Part 3. Application Procedures
317:35-6-15. [AMENDED]
Part 5. Determination of Eligibility for SoonerCare for Pregnant Women and Families with Children
317:35-6-35. [AMENDED]
317:35-6-36. [AMENDED]
317:35-6-37. [AMENDED]
317:35-6-38. [REVOKED]
317:35-6-39. [NEW]
317:35-6-40. [NEW]
317:35-6-41. [NEW]
317:35-6-42. [NEW]
317:35-6-43. [NEW]
317:35-6-44. [NEW]
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317:35-6-50. [NEW]
317:35-6-51. [NEW]
317:35-6-52. [NEW]
317:35-6-53. [NEW]
317:35-6-54. [NEW]
Part 7. Certification, Redetermination and Notification
317:35-6-60. [AMENDED]
317:35-6-60.1. [NEW]
317:35-6-61. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
317:35-7-15. [REVOKED]
Part 5. Determination of Eligibility for Medical Services
317:35-7-35. [REVOKED]
317:35-7-37. [REVOKED]
317:35-7-48. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-7-60.1. [AMENDED]
317:35-7-63. [REVOKED]
317:35-7-64. [REVOKED]
317:35-7-65. [REVOKED]
317:35-7-66. [REVOKED]
Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 7. Determination of Financial Eligibility
317:35-9-67. [AMENDED]
Part 9. Certification, Redetermination and Notification
317:35-9-75. [AMENDED]
Subchapter 10. Other Eligibility Factors for Families with Children and Pregnant Women
Part 3. Resources
317:35-10-10. [AMENDED]
Part 5. Income
317:35-10-25. [AMENDED]
317:35-10-26. [AMENDED]
Subchapter 13. Member Rights and Responsibilities
317:35-13-1. [AMENDED]
317:35-13-2. [AMENDED]
Subchapter 15. Personal Care Services
317:35-15-5. [AMENDED]
317:35-15-6. [AMENDED]
317:35-15-7. [AMENDED]
Subchapter 19. Nursing Facility Services
317:35-19-19. [AMENDED]
317:35-19-20. [AMENDED]
317:35-19-22. [AMENDED]
Subchapter 21. Oklahoma Cares Breast and Cervical Cancer Treatment Program
317:35-21-13. [AMENDED]
**(Reference APA WF # 12-41B)**
**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 111-148 and 111-152; Section 1920 of the Social Security Act; Section 473 of the Social Security Act
**DATES:**
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**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**

Eligibility rules are amended to provide that eligibility for children, pregnant women, and parents and caretaker relatives is determined using the Modified Adjusted Gross Income (MAGI) methodology, as mandated by federal law. Rules are amended to add two eligibility groups mandated by federal law: former foster care children aged 19-26 and CHIP children who would lose eligibility as a result of the MAGI method. Rules regarding eligibility determination procedures are amended to establish the passive renewal process mandated by federal law, as well as the federal rule that medical verification of pregnancy can only be required when the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency.

Eligibility rules are also amended to add the mandatory eligibility group of children receiving Kinship Guardianship Assistance. Because the State has established a kinship guardianship assistance program, SoonerCare eligibility is mandated by federal laws and regulations. These amendments will provide eligibility coverage whether the child receives the assistance through the program established by OKDHS or through kinship guardianship programs that may be established by tribes in the future.

In addition, eligibility rules are amended to eliminate presumptive eligibility (PE) for pregnant women. Under the PE program, certain qualified SoonerCare providers used to determine pregnant women presumptively eligible for SoonerCare; the women then had 30 days to apply and be fully determined eligible or ineligible. The purpose of PE was to give pregnant women access to care quickly. PE is no longer used because pregnant women can now have their eligibility fully determined in real-time through Online Enrollment.

**CONTACT PERSON:**
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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

### 317:35-1-1. Purpose

The purpose of this Chapter is to provide the rules for the Oklahoma Health Care Authority's (OHCA) Title XIX (Medicaid) and Title XXI (CHIP)~~program~~programs for adults and children. The Authority provides payment for medical services to adults and children, within the scope of the program, on behalf of individuals who meet the eligibility requirements for Title XIX (Medicaid) or Title XXI (CHIP).

### 317:35-1-2. Definitions

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

**"Acute Care Hospital"** means an institution that meets the requirements of 42 CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

**"ADvantage Administration (AA)"** means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

~~**"AFDC"** means Aid to Families with Dependent Children.~~

**"Aged"** means an individual whose age is established as 65 years or older.

**"Agency partner"** means an agency or organization contracted with the OHCA that will assist those applying for services.

**"Aid to Families with Dependent Children (AFDC)"** means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Effective January 1, 2014, children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

**"Area nurse"** means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

**"Area nurse designee"** means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

**"Authority"** means the Oklahoma Health Care Authority (OHCA).

**"Blind"** means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

**"Board"** means the Oklahoma Health Care Authority Board.

**"Buy-in"** means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

**"Caretaker relative"** means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

**"Case management"** means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

**"Categorically needy"** means that income and when applicable, resources are within the standards for the category to which the individual is related.

**"Categorically related" or "related"** means the individual ~~is:~~meets basic eligibility requirements for an eligibility group.

~~(A) aged, blind, or disabled;~~

~~(B) pregnant;~~

~~(C) an adult individual who has a minor child under the age of 18; or~~

~~(D) a child under 19 years of age.~~

**"Certification period"** means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

**"County"** means the Oklahoma Department of Human Services' office or offices located in each county within the State.

**"Custody"** means the custodial status, as reported by the Oklahoma Department of Human Services.

**"Deductible/Coinsurance"** means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for in-patient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

**"Disabled"** means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

**"Disabled child"** means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

**"Estate"** means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

**"Gatekeeping"** means the performance of a comprehensive assessment by the OKDHS nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

**"Local office"** means the Oklahoma Department of Human Services' office or offices located in each county within the State.

**"LOCEU"** means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

**"MAGI eligibility group"** means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 CFR 435.603 and listed in OAC 317:35-6-1.

**"Modified Adjusted Gross Income (MAGI)"** means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

**"Medicare"** means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been

receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

**"Minor child"** means a child under the age of 18.

**"Nursing Care"** for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for the mentally retarded or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

**"OCSS"** means the Oklahoma Department of Human Services' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

**"OHCA"** means the Oklahoma Health Care Authority.

**"OHCA Eligibility Unit"** means the group within the Oklahoma Health Care Authority that assists with the eligibility determination process.

**"OKDHS"** means the Oklahoma Department of Human Services.

**"OKDHS nurse"** means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

**"Qualified Disabled and Working Individual (QDWI)"** means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

**"Qualified Medicare Beneficiary Plus (QMBP)"** means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

**"Qualifying Individual"** means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

**"Qualifying Individual-1"** means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

**"Reasonably compatible"** means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

**"Recipient lock-in"** means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

**"Scope"** means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

**"Specified Low Income Medicare Beneficiaries (SLMB)"** means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

**"TEFRA"** means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays are expected to last not less than 60 days.

**"Worker"** means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

**317:35-1-3. Legal bases**

The Federal legal base of the Medical Assistance program is vested in ~~Title~~Titles XIX and XXI of the Federal Social Security Act. The State Legal base is vested in 56 O.S. 1981, Sec. 328 et seq.

## SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

## PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

**317:35-5-1. Scope and applicability**

The provisions in this Part apply to all individuals requesting medical services ~~who meet the definitions of categorically needy~~ within the scope of the ~~Medicaid~~SoonerCare Program. ~~See Part 5 of this Subchapter for income and resource determinations specific to the different categories.~~

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

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, ~~Categorical~~ categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to the pregnancy~~-related services~~group is established when the determination is made by medical evidence that the individual is or has been pregnant. Effective January 1, 2014, verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age 19 or over to be related to ~~AFDC~~the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged 19-26, and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) ~~Aid to Families with Dependent~~ Children, also including
  (A) Newborns deemed eligible, and
  (B) Grandfathered CHIP children
(6) Parents and Caretaker Relatives
(~~6~~7) Refugee
(~~7~~8) Breast and Cervical Cancer Treatment program
(~~8~~9) SoonerPlan Family Planning Program
(~~9~~10) Benefits for pregnancies covered under Title XXI~~.~~
(11) Former foster care children.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21~~ who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan~~.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:
  (A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or
  (B) in adoptions subsidized in full or in part by a public agency; or
  (C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

**317:35-5-6. Determining categorical relationship to pregnancy-related services**

(a) For applications made prior to January 1, 2014, ~~Categorical~~categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within 30 days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within 30 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the thirty day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the member's statement.

(b) Effective January 1, 2014, women who are pregnant, including 60 days postpartum, are related to the pregnant women group. Pregnancy does not have to be verified unless the declaration that an applicant or member is pregnant is not reasonably compatible with other information available to the agency. The individual must also provide the expected date of delivery.

**317:35-5-6.1. Determining categorical relationship for pregnancy related services covered under Title XXI**

(a) For applications made prior to January 1, 2014, ~~Categorical~~categorical relationship for pregnancy related benefits covered under Title XXI ~~are~~is determined in accordance with OAC 317:35-22-1 and through medical evidence that the individual is currently or has recently been pregnant and may

qualify for pregnancy related services. Pregnancy must be verified by providing medical proof of pregnancy within 30 days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within 30 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the thirty day period. The applicant must be residing in the State of Oklahoma with the intent to remain at the time the medical service is received. The expected date of delivery must be established either by information from the applicant's physician or other qualified practitioner.

(b) Effective January 1, 2014, relationship to the pregnancy-related services group under Title XXI is determined in accordance with OAC 317:35-22-1. Pregnancy does not have to be verified unless the declaration that an applicant or member is pregnant is not reasonably compatible with other information available to the agency. The individual must also provide the expected date of delivery.

**317:35-5-7. Determining categorical relationship to ~~AFDC~~the children and parent and caretaker relative groups**

(a) **Categorical relationship.** All individuals under age 19 are automatically related to ~~AFDC~~the children's group and further determination is not required. Adults age 19 or older are related to ~~AFDC~~the parent and caretaker relative group when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

(b) **Grandfathered CHIP children.** As provided in OAC 317:35-6-1, the MAGI methodology is not applied to determine eligibility for children who are enrolled in SoonerCare on December 31, 2013 until March 31, 2014 or the child's next regularly scheduled renewal, whichever is later.

(1) The MAGI methodology eliminates the following income disregards, which are subtracted from gross income under the TANF methodology prior to January 1, 2014:

(A) The $240 work related expense deduction from earned income per employed household member;

(B) The disregard of the first $50 of child support received by a household; and

(C) The deduction for child support expenses paid by an employed parent or caretaker who needs child care in order to work, in the amount of the actual expense paid up to a maximum of $200 per month for children under 2 years of age and up to a maximum of $175 per month for children 2 years of age or older.

(2) If the elimination of the disregards listed in (1) when the MAGI methodology is applied to a child who was enrolled in SoonerCare on December 31, 2013 makes the child financially ineligible, the child is related to the Grandfathered CHIP children group.

(3) The following children are not eligible for the Grandfathered CHIP Children group:

(A) Children who are eligible for SoonerCare through another eligibility group;

(B) Children who have other creditable health insurance coverage;

(C) Children who are inmates of public institutions or are patients in institutions for mental disease; or

(D) Children who are eligible for coverage under a health plan offered to employees of the State of Oklahoma.

(4) If a child's eligibility in this group is redetermined during his/her certification period and the child is financially ineligible without regard to elimination of the disregards in (1), the child's benefits are closed using normal procedures.

(5) Eligibility for children in this group expires on the date of the child's next regularly scheduled recertification after the recertification for which the MAGI methodology was first used. This eligibility group terminates for all children December 31, 2015.

(~~b~~c) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, ~~his/her needs cannot be included in the benefit group~~ he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for ~~a~~ child(ren) ~~only~~ or pregnant women to receive SoonerCare ~~case~~.

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

All non-pregnant women and men ages 19 and older, regardless of pregnancy or paternity history, ~~with family income at or below 185% of the federal poverty level and~~ who are otherwise ineligible for SoonerCare are categorically related to the SoonerPlan Family Planning Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in SoonerPlan with the option of applying for SoonerCare at any time.

## PART 5. COUNTABLE INCOME AND RESOURCES

**317:35-5-43. Third party resources; insurance, workers' compensation and Medicare**

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. The

applicant or member must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, and submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for adoption. Any agreement with an adoption agency or attorneys shall include payment of medical care and must be considered as a possibly liable third party, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage.

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. They are considered a third party liability source.

(2) **Workers' Compensation.** An applicant for SoonerCare or a SoonerCare member that requires medical care because of a work injury or occupational disease must notify OHCA/TPL immediately and assist OHCA in ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.). The OHCA periodically matches data with the Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member is obtained, the member must assist OHCA with the subrogation claim with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the member is responsible for reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, the worker submits any information available to OHCA/TPL.

(B) If OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the need for services may have resulted from an accident or injury involving third party liability, OHCA will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, the local OKDHS office or OHCA representative may be requested by the OHCA/TPL Unit to submit the appropriate information.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the information is cleared with the Social Security Office and the findings entered with the date of the verification in the record. If the applicant did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services Oklahoma Child Support Services (OCSS) in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to ~~AFDC, AB or AD~~the children's, the blind, or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility if it is counted under the financial eligibility methodology used for the group for which eligibility is being determined. The rules in OAC 317:10 are used, with the following exceptions:

(i) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(ii) Prior to January 1, 2014, ~~Child/spousal~~child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the CFSD or retained by the member. Effective January 1, 2014, see rules regarding financial eligibility for the individual's eligibility group to determine whether child/spousal support is counted as income.

(iii) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OCSS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's

gross income. The administration and collection of cash medical support will be determined by OKDHS OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to OKDHS/OCSS guidelines.

**317:35-5-44. Child/spousal support**

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services to provide Child Support Services to certain families receiving SoonerCare benefits through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights. These families will not be required to cooperate with the OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to ~~AFDC, AB or AD~~the children's, the blind or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). ~~The child support income continues to be counted in determining SoonerCare eligibility.~~ The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(2) Prior to January 1, 2014, ~~Child/spousal~~child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the OCSS or retained by the member. Effective January 1, 2014, see rules regarding financial eligibility for the individual's eligibility group to determine whether child or spousal support is counted as income.

(3) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

**317:35-5-45. Determination of income and resources for ~~categorical relationship to AFDC~~children and parents and caretaker relatives**

(a) **Prior to January 1, 2014.** 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 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 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 SoonerCare eligibility, a period of ineligibility is not computed;

(5) mandatory inclusion of minor blood-related siblings or minor dependent children. For SoonerCare purposes, the family has the option to exclude minor blood-related siblings and/or minor dependent children;

(6) the disregard of one half of the earned income;

(7) dependent care expense. For 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;

(8) AFDC trust rule. The availability of trusts for all SoonerCare only cases is determined according to OAC 317:35-5-41.6;

(9) AFDC Striker rules. Striker status has no bearing on SoonerCare eligibility;

(10) ET&E Sanction rule. The ET&E status has no bearing on SoonerCare eligibility. However, a new SoonerCare application is required.

(b) **Effective January 1, 2014.** Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to the children and parent and caretaker relatives groups. See Subchapter 6 of this Chapter for MAGI rules.

**317:35-5-46. Determination of income and resources for categorical relationship to pregnancy-related services**

(a) **Prior to January 1, 2014.** Countable income for an individual categorically related to pregnancy-related services is determined in the same manner 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. Individuals categorically related to pregnancy-related services are excluded from a resource test.

(b) **Effective January 1, 2014.** Income is determined in accordance with the Modified Adjusted Gross Income (MAGI)

methodology for individuals related to the pregnancy group. See Subchapter 6 of this Chapter for MAGI rules. Eligibility is based on the income received in the first month of certification with changes in income not considered after certification, and there is no resource test.

## PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

### 317:35-5-60. Application for SoonerCare; forms

(a) **Application.** An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. Effective January 1, 2014, the application form is available as an online application, as a paper form, and is available to be completed by telephone with the assistance of the agency.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, have children or are applying for family planning services only. A face to face interview is not required. Only SoonerCare applications for women who are pregnant, families with children and for family planning services are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or 08MA005E for individuals who are pregnant, have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. Effective October 1, 2013, an application for SoonerCare may also be submitted through the Health Insurance Exchange.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification of a need for medical services. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

### 317:35-5-61. [RESERVED]

### 317:35-5-62. [RESERVED]

### 317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by OHCA.** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) children
(2) newborns deemed eligible
(3) grandfathered CHIP children
(4) pregnant women
(5) pregnancy-related services under Title XXI
(6) parents and caretaker relatives
(7) former foster care children
(8) Oklahoma Cares Breast and Cervical Cancer program
(9) SoonerPlan Family Planning program.

(b) **Determination of eligibility by OKDHS.** OKDHS is responsible for determining eligibility for the following eligibility groups:

(1) TANF recipients
(2) recipients of adoption assistance or kinship guardianship assistance
(3) state custody
(4) Refugee Medical Assistance
(5) aged
(6) blind
(7) disabled
(8) Tuberculosis
(9) QMBP
(10) QDWI
(11) SLMB
(12) QI-1
(13) Long term care services
(14) alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** Effective October

1, 2013, OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

**317:35-5-64. Cooperation in determination of eligibility**

(a) If an applicant does not cooperate in determination of eligibility and/or the agency does not have sufficient information to determine or redetermine eligibility, the application is denied or benefits are terminated for that reason. The agency responsible for determining eligibility provides the applicant with notice of outstanding requirements that must be met before eligibility can be determined.

(b) If an applicant or member cannot be located to assist in determination or redetermination of eligibility, the application is denied or benefits are terminated. Notice is sent to the applicant or member's last known address.

## SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

## PART 1. GENERAL

**317:35-6-1. Scope and applicability**

(a) The rules in this Subchapter apply when determining financial eligibility for SoonerCare Health Benefits for ~~Pregnant Women and Families with Children when the individual is categorically needy.~~ groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:

(1) Children,
(2) Grandfathered CHIP children,
(3) Pregnant women,
(4) Pregnancy-related services under Title XXI,
(5) Parents and caretaker relatives,
(6) SoonerPlan Family Planning program,
(7) Independent foster care adolescents,
(8) Inpatients in public psychiatric facilities under 21, and
(9) Tuberculosis.

(b) See 42 CFR 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.

(c) MAGI rules are not applied to members enrolled in SoonerCare on December 31, 2013 until March 31, 2014, or the date of their next regularly scheduled renewal, whichever is later.

(d) For new applicants or individuals who have had a break in eligibility and are not enrolled on December 31, 2013, MAGI rules take effect on January 1, 2014.

## PART 3. APPLICATION PROCEDURES

**317:35-6-15. Application for SoonerCare for Pregnant Women and Families with Children; forms**

(a) **Application.** An application for ~~categorically needy~~ pregnant women and families with children consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. ~~A categorically needy~~An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, in the county OKDHS office, or online. A face to face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. Effective October 1, 2013, an application for SoonerCare may also be submitted through the Health Insurance Exchange.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification ~~for~~of a need for medical ~~service~~services. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five days from the date services are rendered. The hospital, applicant, or someone acting on the applicant's behalf has fifteen days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a Notification of Date of Service does not guarantee coverage and if a completed application is not submitted within fifteen days, the NODOS is void.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and

forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

(c) **Other application and signature requirements.** For additional rules regarding other application and eligibility determination procedures, see Part 7 of Subchapter 5 of this Chapter.

## PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

### 317:35-6-35. General eligibility consideration~~; categorically related family members~~

(a) **Prior to January 1, 2014.** Financial eligibility for SoonerCare Health Benefits for Pregnant Women and Families with Children is determined using the rules on income according to the category to which the individual is related. (See Part 5, Subchapter 5 of this Chapter.) Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification. There is not a resource test for individuals categorically related to AFDC or pregnancy related services.

(b) **Effective January 1, 2014.** Financial eligibility for SoonerCare Health Benefits for MAGI eligibility groups is determined using the MAGI methodology. Unless questionable, the income of individuals who are related to a MAGI eligibility group does not require verification. There is no resource test for individuals related to any of the MAGI groups (see Part 1 of this Subchapter for a list of the MAGI groups).

(~~1~~c) When medical assistance is requested on behalf of any individual, eligibility is determined for that individual as well as all other individuals in the family unit who ~~are categorically related~~meet basic criteria for a SoonerCare eligibility group. ~~In instances where individuals in a family unit are categorically related to different categories, the sequence for determining financial eligibility is as follows:~~

~~(A) First, eligibility must be established for the individual categorically related to ABD (see OAC 317:35-5-7).~~

~~(B) Second, financial eligibility is determined for family members who are categorically related to AFDC and/or pregnancy-related services.~~

(d)~~(2)~~Income is evaluated on a monthly basis for all individuals included in the case for Health Benefits.

### 317:35-6-36. Financial eligibility of individuals categorically related to AFDC or pregnancy-related services

(a) **Prior to January 1, 2014.** In determining financial eligibility for an individual related to AFDC or pregnancy-related services, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include:

(1) the individual;

(2) the spouse of the individual;

(3) the biological or adoptive parent(s) of the individual who is a minor dependent child. For Health Benefits only, income of the stepparent of the minor dependent child is determined according to OAC 317:35-5-45;

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

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

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

(b) **Prior to January 1, 2014.** The family has the option to exclude minor dependent children or blood related siblings [OAC 317:35-6-36(a)(4) and (5)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income ~~[see OAC 317:35-10-56(b)]~~ must be included in the case. The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income.

(c) **Effective January 1, 2014.** The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through OAC 317:35-6-54.

(d) **Effective January 1, 2014.** Individuals who are determined to be part of a MAGI household cannot be excluded from the household; likewise, income of individuals determined to be part of a MAGI household cannot be excluded unless the exclusion is expressly required under MAGI rules.

(~~c~~e) When determining financial eligibility for an individual related to ~~AFDC~~the children, parent or caretaker relative, or pregnancy~~-related services~~groups, consideration is not given to income of any person who is aged, blind or disabled and receives SSI or is determined to be categorically needy.

### 317:35-6-37. Financial eligibility of categorically needy individuals related to AFDC or pregnancy-related services

Individuals whose income is less than the ~~categorically needy~~ standards on DHS Appendix C-1 for the applicable eligibility group are ~~considered categorically needy~~financially eligible for SoonerCare.

(1) **Categorically needy standards/categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be ~~categorically needy~~financially eligible, the countable income must be less than the appropriate standard according to the family size on DHS Appendix C-1~~, Schedule I.A., which is 185% of the Federal Poverty Level~~. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **Categorically needy standards/categorically related to ~~AFDC~~children's and parent/caretakers' groups.**

(A) **Categorical relationship.** For the individual related to AFDC to be considered categorically needy, the standards on DHS Appendix C-1 schedules must be used.

(i) **DHS Appendix C-1, Schedule X.** Individuals age 19 years or older, other than pregnant women, are determined categorically needy if countable income is less than the Categorically Needy Standard, according to the family size. Income standards are 73.1% of the AFDC Need Standard.

(ii) **DHS Appendix C-1, Schedule I. A.** All individuals under 19 years of age are determined categorically needy if countable income is equal to or less than the Categorically Needy Standard, according to the size of the family. Income standards are 185% of Federal Poverty Level.

(B) ~~**Individuals categorically needy/related to AFDC**~~**Families with children.** Individuals who meet ~~the definition of categorically needy and related to AFDC are~~financial eligibility criteria for the children's and parent/caretakers' groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to ~~AFDC,~~the children's or parent/caretakers' groups whose countable income is within the current appropriate ~~categorically needy~~ income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in Work Supplementation status who meet TANF eligibility conditions other than earned income.

(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the caretaker relative.

**317:35-6-38. Presumptive eligibility for pregnant women [REVOKED]**

~~(a) Presumptive Eligibility (PE) is a limited period of SoonerCare eligibility for categorically needy pregnant women that is determined by a qualified provider. Its purpose is to encourage pregnant women to receive adequate prenatal care in the earlier months of their pregnancy, and to ensure qualified providers of payment for the prenatal care. The PE period precedes the SoonerCare eligibility determination and begins on the date a qualified provider makes a determination of presumptive eligibility. The basis for the determination is preliminary information that the net family income of the pregnant woman does not exceed the standards on the OHCA website or the OKDHS form 08AX001E, Schedule I, which are 185% of the Federal Poverty Level.~~

~~(b) Pregnant women are excluded from a resource test. When a qualified provider has made this determination, the provider is required to notify the county office in the OHCA Eligibility Unit within five working days after the date of PE determination. The OHCA Eligibility Unit does not make PE determinations. When a PE determination is received, the worker determines SoonerCare eligibility using normal procedures.~~

~~(1) **Qualified providers.** The determination that a provider is qualified to make a PE determination is made by the OHCA. A listing of approved qualified providers is found on the OHCA website. The OHCA Eligibility Unit must be sure a PE determination is made only by a qualified provider.~~

~~(2) **Application and eligibility determination process for presumptive eligibility.** The OHCA Eligibility Unit supplies the qualified providers with the necessary forms and instructions to complete and correctly determine PE for pregnant women.~~

~~(A) The forms include the following:~~

~~(i) The SoonerCare Application. This form must be completed at the PE determination and serves to gather information to complete PE determination and also to use for SoonerCare eligibility determination;~~

~~(ii) OHCA Form MA-PE-1, Presumptive Eligibility Budget Sheet, which is completed by the qualified provider to verify pregnancy and provide income screening necessary to determine PE. Instructions for completing the form and eligibility rules are included on the back of the form; and~~

~~(iii) OHCA Form MA-PE-2, Notice to Pregnant Women Regarding Presumptive Eligibility for SoonerCare, which is completed and given to the pregnant woman by the qualified provider. It informs her whether she has been determined to be presumptively eligible or ineligible by the qualified provider. It also contains information regarding the application process as well as a detailed list of what is needed to complete the SoonerCare application.~~

~~(B) After determining the pregnancy of the individual, the qualified provider determines financial eligibility. OHCA Form MA-PE-1 is completed to document the pregnancy and the financial eligibility. If the qualified provider determines the individual meets PE requirements, OHCA Form MA-PE-2 is completed and given to the individual. The originals of the SoonerCare Application form and OHCA Form MA-PE-1 are sent to the OHCA Eligibility Unit. They must be received within five working days after the date of the PE determination.~~

~~(C) If the individual is determined by the qualified provider to not meet PE requirements, the qualified provider completes OHCA Form MA-PE-2 and gives it to the individual. The qualified provider also advises the individual she may be eligible for SoonerCare and refers her to the on-line application or the~~

~~OKDHS county office for SoonerCare eligibility determination.~~

~~(D) A PE determination may be made at any time during a pregnancy, even if there is an application pending. Only one PE period will be granted during a pregnancy.~~

~~(E) Only a pregnant woman may be determined as PE. No other household member may be certified as presumptively eligible.~~

~~(3) **Household definition.** For purposes of this Section, the household is defined as the pregnant woman, her spouse or male acting in the role of the spouse, and her minor dependent children. The unborn child(ren) is also included as a member(s) of the household. If the pregnant woman is under age 18 and lives with her parent(s), the parent(s) is considered a household member(s). Other minor siblings may be included as household members.~~

~~(4) **Income computation.** The PE determination of the pregnant woman requires the provider to compute the total monthly income of the household as shown on the SoonerCare Application. The total monthly income includes the earned and unearned income of all household members. If the pregnant woman is a minor (under age 18) and lives with her parents, her parents' income must be included, regardless of the minor pregnant woman's marital status. The income included in the PE determination is the total income received in the month that PE is determined by the qualified provider. The household's total net income must be equal to or less than the standards on the OHCA website or the OKDHS Form 08AX001E, Schedule I, which are 185% of the Federal Poverty Level.~~

~~(A) Countable earned income is the gross earnings of each household member minus the AFDC work related expenses and paid dependent care expenses not to exceed the AFDC dependent care limits (see OAC 317:35-10). Countable unearned income is the total unearned income of all household members. The AFDC rule on unearned income exclusions is followed.~~

~~(B) The total countable net earned income plus the total countable unearned income is the total countable net income. This total and the household size is compared to the standards on OHCA Form MA-PE-1 to determine financial eligibility.~~

~~(5) **Presumptive eligibility period.** Presumptive eligibility begins on the date a qualified provider determines the total countable monthly net income of a pregnant woman's household does not exceed the eligibility standard on the OHCA website or OKDHS Form 08AX001E, Schedule I. Presumptive eligibility ends with (and includes) the earlier of:~~

~~(A) The day an eligibility or ineligibility determination is made; or~~

~~(B) The 45th day after the date on which the qualified provider made the PE determination (the 45 day count begins on the day following the eligibility determination date).~~

~~(6) **Approval of presumptive eligibility.** When the OHCA Eligibility Unit receives timely a completed PE certification, a case number, if needed, is assigned. The PE certification is processed within five working days. The applicant is notified of the PE determination by computer generated notice. The notice also advises that the PE period expires 45 days from the date of the qualified provider's approval. The case is automatically closed at the end of the 45 day period if a decision has not been made on the SoonerCare application.~~

~~(7) **Incomplete/incorrect presumptive eligibility forms.** Upon receipt of the SoonerCare Application and OHCA Form MA-PE-1 from the qualified provider, the OHCA Eligibility Unit immediately screens them for completeness and correct determination.~~

~~(A) The SoonerCare Application for PE is considered incomplete if it is not filled out in its entirety, properly signed and dated. OHCA Form MA-PE-1 is considered incomplete if any response is omitted or if the form is not properly signed and dated.~~

~~(B) The presumptive eligibility determination is considered to be incorrect if the provider submitting the certification has not been determined to be a qualified provider by the OHCA. The presumptive eligibility decision is also incorrect if the income computed by the qualified provider exceeds the allowable standard.~~

~~(C) When it is determined the PE certification is incomplete or incorrect, the original OHCA Form MA-PE-1 and a copy of the SoonerCare application, are returned to the qualified provider. The worker proceeds with the SoonerCare eligibility determination. To maintain the original PE certification period, the qualified provider must correct and/or complete the forms and return them to the OHCA Eligibility Unit within the original five working days. If this requirement is not met, an amended PE determination and PE determination date must be completed by the provider.~~

~~(8) **Presumptive eligibility forms not received within five working days.** A qualified provider is required to provide the PE determination to the OHCA Eligibility Unit within five working days after the date of the PE determination. The forms must be complete and correct as explained in paragraph (7) of this subsection. Forms received on the sixth day (or later) after the PE determination date are returned to the qualified provider with a request for an amended PE determination and PE determination date.~~

~~(9) **Erroneous payments and appeal rights.** When an individual is certified as presumptively eligible and a determination is made later that the individual is not eligible for SoonerCare, the PE period ends with the effective date of the SoonerCare application denial. In this instance, the effective date of denial is the day following the date the ineligibility decision is made.~~

~~(A) If the ineligibility is not due to a misrepresentation by the applicant, any payments made are not~~

~~considered to be erroneous. If the ineligibility is due to the applicant withholding or misrepresenting information, any payments made are considered to be erroneous and a recipient overpayment is submitted to OKDHS State Office, FSS Overpayment Section.~~

~~(B) The applicant cannot appeal a PE determination made by a qualified provider or the expiration of the PE period (45 days).~~

**317:35-6-39. General calculation of countable income for MAGI eligibility groups**

(a) The income that is counted in determining eligibility for an individual is that individual's household income.

(b) In order to calculate the countable household income for an individual:

(1) Determine who is in the individual's household (see OAC 317:35-6-40 to 317:35-6-43);

(2) Identify all sources of income for all household members;

(3) Determine whether each source of income is considered for SoonerCare eligibility or is excluded (see Part 6, Countable Income, of this Subchapter);

(4) Determine the gross monthly amount of each source of countable income (see Part 6, Countable Income, of this subchapter);

(5) Determine whether each household member's income counts toward the household (see 317:35-6-44);

(6) Sum the gross monthly amounts of all countable sources of income of all household members whose income is counted;

(7) Subtract allowable adjustments to income (see OAC 317:35-6-52); and

(8) Compare the result to the income limit for the individual's eligibility group (see the appropriate Schedule of OKDHS Appendix C-1). If the result is equal to or less than the dollar amount of the income limit, the individual is financially eligible.

(9) When calculating the percentage of the Federal Poverty Level (FPL) that corresponds to the individual's monthly countable income, subtract 5% from the FPL percentage reached to determine the countable FPL level for the individual. This countable percentage of FPL is compared to the FPL limit for the individual's eligibility group in order to determine whether the individual is financially eligible. This 5% deduction from FPL has already been accounted for in the dollar amounts of the income limits given in OKDHS Appendix C-1.

(c) If an individual's household income using this methodology is over the income limit for SoonerCare eligibility and that individual's household income using the MAGI household and income-counting methodology used by the Federally Facilitated Exchange (FFE) is less than 100% of FPL, the FFE's MAGI rules, as promulgated by the Internal Revenue Service, are used to determine SoonerCare eligibility in place of the rules in this Chapter. The FFE rules including, but not limited to, those in the following areas may need to be followed in place of the SoonerCare rules in this Chapter:

(1) Rules on household composition;

(2) Rules on countable sources of income; and

(3) Rules on the budget period used to calculate income, i.e. annual income (FFE) versus current monthly income (SoonerCare).

**317:35-6-40. MAGI household composition; taxpayers and tax dependents**

(a) The rules used to determine MAGI household composition depend on tax relationships.

(b) Whether an individual is a taxpayer or a tax dependent at the time of application is determined by whether the applicant expects to file taxes or expects to be claimed as a tax dependent by another taxpayer for the current tax year in which the determination of eligibility for SoonerCare is made.

**317:35-6-41. MAGI household composition; tax filers**

(a) **Scope.** This section applies to individuals who expect to file taxes themselves or who expect to be claimed by another taxpayer as a tax dependent for the taxable year in which the eligibility determination is being made.

(b) **Taxpayers.** The household of an individual who expects to be a taxpayer consists of him or herself and all of the tax dependents he or she expects to claim.

(c) **Tax dependents.** If an individual expects to be both a taxpayer and a tax dependent, the individual is considered a tax dependent. Unless an exception listed in OAC 317:35-6-42 applies, the household of an individual who expects to be claimed as a tax dependent consists of the taxpayer claiming him or her and all other dependents expected to be claimed by that taxpayer.

(d) **Spouses.** Spouses who live together are always counted in each other's households, regardless of whether or how they expect to file taxes, and regardless of whether one or both of them expect to be claimed as a tax dependent by another taxpayer.

(e) **Unborn children.** If any member of the household is pregnant, the number of children she expects to deliver is counted in the household size of all households of which she is a member.

(f) **No option to exclude.** Individuals may not choose to exclude any person counted as a household member under this rule from the household.

**317:35-6-42. MAGI household composition; exceptions to tax filer rules**

(a) The tax filer household composition rules in OAC 317:35-6-41 do not apply to the following individuals:

(1) Individuals who expect to be claimed as a tax dependent by a taxpayer who is not their spouse or biological, adoptive, or step parent, regardless of the individual's age;

(2) Individuals under the age of 19 who are living with two parents, whose parents do not expect to file a joint return, and who expect to be claimed as a dependent by one of their parents; or

(3) Individuals under the age of 19 who expect to be claimed as a tax dependent by a non-custodial parent.

(b) The non-filer household composition rules in OAC 317:35-6-43 apply to individuals who are claimed as tax dependents but are described in one of the exceptions to the tax filer rules in (a).
(c) If an individual's declaration that another person is a tax dependent is not reasonably compatible with other information available to OHCA, the non-filer household composition rules are used to determine whether the person will be included in the household of the taxpayer.

**317:35-6-43. MAGI household composition; non-filers**
(a) The household composition defined in this section applies to individuals who do not expect to file taxes and do not expect to be claimed as a tax dependent by another taxpayer for the taxable year during which eligibility is being determined. This section also applies to individuals described in an exception to the tax filer household in OAC 317:35-6-42.
(b) The non-filer household consists of the individual, and if applicable and if living with the individual:
(1) the individual's spouse;
(2) the individual's natural, adopted and step children under the age of 19;
(3) if the individual is under the age of 19, the individual's natural, adoptive and step parents; and
(4) if the individual is under the age of 19, the individual's natural, adoptive and step siblings who are also under the age of 19.
(c) If any member of the household is pregnant, the number of children she expects to deliver is counted in the household size of all households of which she is a member.
(d) Individuals may not choose to exclude any person counted as a household member under this rule from the household.

**317:35-6-44. Determination of whether a household member's income is counted**
(a) Unless a household member falls into an exception listed in this Section, his or her income counts for him or herself and for all members of all households of which the individual is a member.
(b) The income of the following individuals is not included in household income of the household to which the exception applies:
(1) Individuals included in a household of which their biological, adoptive or step parent(s) is/are also member(s), who are not expected to be required to file a tax return for the tax year during which eligibility is being determined (regardless of whether the individual later does in fact file a tax return, and regardless of the individual's age); and
(2) Individuals claimed as tax dependents by someone other than their spouse or biological, adoptive or step parent who are not expected to be required to file a tax return for the tax year during which eligibility is being determined (regardless of whether the individual does in fact file a tax return, and regardless of the individual's age).
(c) If an individual's income is excluded from the household of a parent or of the taxpayer claiming him or her as a dependent because one of the exceptions in paragraph (b) of this section applies, the individual's income is still included in other households of which the individual is also a member, provided no exceptions listed in this section apply to those households.
(d) See 317:35-10-38 for rules regarding temporary absence from the home.

## PART 6. COUNTABLE INCOME FOR MAGI

**317:35-6-50. Countable sources of income**
Unless an exception listed in OAC 317:35-6-51 applies, all income included in Modified Adjusted Gross Income in Section 36B of the Internal Revenue Code is included in the MAGI calculation for SoonerCare eligibility.

**317:35-6-51. Exceptions to Internal Revenue Code rules**
(a) The following sources of income are excluded from household income for SoonerCare eligibility under MAGI, regardless of whether they are included in MAGI in Section 36B of the Internal Revenue Code:
(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and
(2) The following types of American Indian / Alaska Native income:
(A) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;
(B) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:
(i) Rights of ownership or possession in any lands described in Paragraph (a)(2)(A) of this section; or
(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;
(C) Distributions resulting from real property ownership interests related to natural resources and improvements:
(i) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or
(ii) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;
(D) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;
(E) Student financial assistance provided under the Bureau of Indian Affairs education programs; and

(F) Distributions from Alaska Native Corporations and Settlement Trusts.

(b) Amounts received as a lump sum are counted as income only in the month received (see also OAC 317:35-10-26). If a lump sum amount is received from an income source that is not counted in MAGI according to section 36B(d)(2)(B) of the Internal Revenue Code or the exceptions listed in this section, the amount is not counted.

**317:35-6-52. Adjustments to income**

Amounts subtracted from gross income to calculate MAGI for a household are defined in Section 36B of the Internal Revenue Code. No other deductions are applicable, except the subtraction of 5 percent from the percentage of FPL as provided in OAC 317:35-6-39.

**317:35-6-53. Determination of current monthly income**

(a) **Use of current monthly income.** Current monthly income is used in determinations of financial eligibility at application, when a member reports a change in circumstances, and at renewal. See 317:35-6-39 for potential exceptions.

(b) **Calculation of monthly income.** For computation of monthly income, see OAC 317:35-10-26(e).

(c) **Anticipated income.** Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(d) **Expected changes in income.** Reasonably predictable future increases or decreases in income, such as for contract or seasonal employees, are prorated over the year the income is expected to support the household. The predicted annual amount of the income is divided by 12 to reach the monthly amount.

(e) **Lump sum income.** Whether a particular lump sum is counted in household income depends first on whether the source of the lump sum is a countable source of income according to OAC 317:35-6-50 and OAC 317:35-6-51. See also OAC 317:35-10-26 for detailed rules regarding lump sum income.

**317:35-6-54. Determination of current monthly amount of adjustments to income**

(a) Expenses or losses that qualify as deductions for MAGI according to OAC 317:35-6-52 are totaled to reach an annual amount. The annual amount is then divided by 12 and subtracted from gross monthly income to calculate the household's current monthly MAGI.

(b) Whether a deduction is allowed when it has already been paid or when it has only been incurred is determined in accordance with Section 36B of the Internal Revenue Code.

## PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

**317:35-6-60. Certification for SoonerCare for pregnant women and families with children**

An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the date of certification. The period of certification may not be for a retroactive period unless otherwise prior approved by OHCA. The individual who is categorically needy and related to pregnancy- related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

(1) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(2) **Certification of non-cash assistance individuals ~~categorically needy and~~ related to ~~AFDC~~the children and parent and caretaker relative groups.** The certification period for the individual related to ~~AFDC~~the children or parent and caretaker relative groups is 12 months. The certification period can be less than 12 months if the individual:

(A) is certified as eligible in a money payment case during the 12-month period;

(B) is certified for long-term care during the 12-month period;

(C) becomes ineligible for SoonerCare after the initial month; or

(D) becomes financially ineligible ~~as categorically needy~~.

(i) If an income change after certification causes the case to exceed the ~~categorically needy maximums~~income standard, the case is closed.

(ii) Individuals, however, who are determined pregnant and financially eligible ~~as categorically needy~~ continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period.

(3) **Certification of individuals ~~categorically needy and~~ related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two months following the month the pregnancy ends. Financial ~~Eligibility~~eligibility~~as categorically needy~~ is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(4) **Certification of newborn child deemed eligible.**

(A) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born

to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one. The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(B) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. No other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at OKDHS. The referral enables child support services to be initiated.

(C) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one. If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

(i) loses Oklahoma residence; or

(ii) expires.

(D) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

**317:35-60.1. Changes in circumstances**

(a) **Reporting changes.** Members are required to report changes in their circumstances within 10 days of the date the member is aware of the change.

(b) **Agency action on changes in circumstances.** When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

(c) **Changes reported by third parties.** When the agency receives information regarding a change in the member's circumstances from a third party, such as the Oklahoma Employment Security Commission (OESC) or the Social Security Administration (SSA), the agency will determine whether the information received is reasonably compatible with the most recent information provided by the member.

(1) If the information received is reasonably compatible with the information provided by the member, the agency will use the information provided by the member for determinations and redeterminations of eligibility.

(2) If the information received is not reasonably compatible with the information provided by the member, the agency will determine whether the information received will have an effect on the eligibility of any member of the household.

(A) If the information received has no effect on the eligibility of any member of the household, including the benefit package the member is enrolled in, the agency will take no action.

(B) If the information received has an effect on the eligibility of a member of the household, the agency will request more information from the member, including, but not limited to, an explanation of the discrepancy or verification documenting the correct information regarding the factor of eligibility affected by the information received from a third party.

(C) The agency will give the member proper notice of at least 10 days to respond to the agency's request for information.

(D) If the member does not cooperate in resolving the discrepancy within the timeframe established by the notice, benefits will be terminated.

**317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare**

(a) A periodic redetermination of eligibility for SoonerCare is required ~~on all categorically needy cases related to AFDC~~for all members. The redetermination is made prior to the end of the initial certification period and each 12 months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

(b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.

(c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within 90 days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.

## SUBCHAPTER 7. MEDICAL SERVICES

## PART 3. APPLICATION PROCEDURES

### 317:35-7-15. Application for Medical Services; forms [REVOKED]

~~(a) **Application.** An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. A individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.~~

~~(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, have children or are applying for family planning services only. A face to face interview is not required. SoonerCare applications for women who are pregnant, families with children and for family planning services only are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or 08MA005E for individuals who are pregnant, have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.~~

~~(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.~~

~~(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.~~

~~(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.~~

~~(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.~~

~~(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.~~

## PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

### 317:35-7-35. General eligibility consideration; categorically related family members [REVOKED]

~~Financial eligibility for Medical Services is determined using the rules on income and resources according to the category to which the individual is related. (See Part 5, Subchapter 5 of this Chapter.) There is not a resource test for individuals categorically related to AFDC or pregnancy-related services.~~

~~(1) When Medicaid is requested on behalf of any individual, eligibility is determined for that individual as well as all other individuals in the family unit who are categorically related. In instances where individuals in a family unit are categorically related to different categories, the sequence for determining financial eligibility is as follows:~~

~~(A) First, eligibility must be established for the individual categorically related to ABD (see OAC 317:35-5-7).~~

~~(B) Second, financial eligibility is determined for family members who are categorically related to AFDC and/or pregnancy-related services.~~

~~(2) Income, resources for individuals who are categorically related to ABD, and expenses are evaluated on a monthly basis for all individuals included in the Medicaid case.~~

### 317:35-7-37. Financial eligibility of individuals categorically related to AFDC, or pregnancy-related services [REVOKED]

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

~~(1) the individual;~~

~~(2) the spouse of the individual;~~

~~(3) the biological or adoptive parent(s) of the individual who is a minor dependent child. Income of the stepparent of the minor dependent child is determined according to OAC 35-10-26(a)(8);~~

~~(4) minor dependent children of the individual if the children are being included in the case for Medicaid. If the individual is 19 years or older and not pregnant, at least one minor dependent child must be living in the home and included in the case for the individual to be categorically related to AFDC;~~

~~(5) blood-related siblings, of the individual who is a minor child, if they are included in the case for Medicaid;~~

~~(6) a caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.~~

~~(b) The family has the option to exclude minor dependent children or blood related siblings[see OAC 317:35-7-37(1)(D) and (E)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income [see OAC 317:35-7-37(a)(4)] must be included in the case. When determining financial eligibility for an individual related to AFDC or pregnancy-related services, consideration is not given to income of any person who is aged, blind or disabled and is determined to be categorically needy.~~

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

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

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

(a) Non-pregnant 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), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare 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 applicable standard on the OKDHS Appendix C-1. Prior to January 1, 2014, ~~The~~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). Effective January 1, 2014, MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.

(2) Prior to January 1, 2014, ~~In~~in determining financial eligibility for the SoonerPlan Family Planning program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. Effective January 1, 2014, MAGI household composition rules are used to determine eligibility for SoonerPlan.

(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.

(4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning Program with the option of applying for SoonerCare at any time.

(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.

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

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

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

## PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

**317:35-7-60.1. Certification for the SoonerPlan Family Planning Program~~.~~**

The effective date of certification for the SoonerPlan Family Planning Program is the date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the SoonerPlan Family Planning Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.

**317:35-7-63. Notification of eligibility [REVOKED]**

~~When eligibility for SoonerCare is established, the the appropriate notice is computer generated to the applicant. When the computer file is updated for changes, notices are generated only if there is a change in the SoonerCare eligibility of a household member.~~

**317:35-7-64. Denials [REVOKED]**

~~If denial of SoonerCare is for the entire household, the application is denied and the appropriate notice is computer generated to the applicant. If an individual(s) is being denied but other family members are eligible, the denied individual(s) is provided with a notice.~~

**317:35-7-65. Closures [REVOKED]**

~~SoonerCare cases are closed at any time during the certification period that the case becomes ineligible. A computer generated notice is sent to the head of the household. Otherwise, a case automatically closes at the end of the certification period if eligibility is not redetermined except for children in the custody of OKDHS who are placed outside their own home.~~

**317:35-7-66. Transfer of case records between counties [REVOKED]**

~~Case records on short-term medical care applications, active cases or closed cases are transferred in accordance with OAC 340:65.~~

## SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

## PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

**317:35-9-67. Determining financial eligibility of categorically needy individuals**

Financial eligibility for ICF/MR, HCBW/MR, and individuals age 65 or older in mental health hospitals medical care for categorically needy individuals is determined as follows:

(1) **Prior to January 1, 2014,~~Financial~~financial eligibility/categorically related to AFDC.** In determining income for the individual related to AFDC, all family income is considered. The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(A) spouse; and

(B) parent(s) and minor children of their own. Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.

(i) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule X.

(ii) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule I. A.

(2) **Effective January 1, 2014, financial eligibility in a Modified Adjusted Gross Income (MAGI) eligibility group.** In determining financial eligibility for an individual related to a group for whom the MAGI methodology is used, rules in Subchapter 6 of this Chapter are followed.

(~~2~~3) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the individual's countable income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule VI. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering an ICF/MR, see OAC 317:35-9-68 (a)(3) to determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI, is applicable for individuals related to ABD. If the individual is in an ICF/MR and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard on OKDHS Appendix C-1, Schedule VI, is used. 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 [Refer to OAC 317:35-9-68 (a)(3)(B)(x)]. An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

(B) In determining eligibility for HCBW/MR services, refer to OAC 317:35-9-68(b).

(C) In determining eligibility for individuals age 65 or older in mental health hospitals, refer to OAC 317:35-9-68(c).

(~~3~~4) **Transfer of capital resources on or before August 10, 1993.** Individuals who have transferred capital resources on or before August 10, 1993 and are applying for or receiving NF, ICF/MR or ~~receiving~~ HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this rule. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost ~~($2,000)~~ to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is

defined as the difference between the equity value and the amount received for the resource.

(A) However, the penalty would not apply if:

(i) The transfer was prior to July 1, 1988.

(ii) The title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.

(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(iv) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's resource allowance.

(v) The resource was transferred to the individual's child who is under 21 or who is blind or totally disabled.

(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office, FSSD, Health Related and Medical Services, for a decision.

(B) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF services and the continuance of eligibility for other SoonerCare services.

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual. The cost of care during the penalty period cannot be used to shorten or end the penalty period.

(D) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored resource or the amount of commensurate return.

(E) The restoration or commensurate return will not entitle the member to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, HCBW/MR, or ADvantage waiver services for a period of resource ineligibility.

(~~4~~5) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look-back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an ICF/MR or receiving HCBW/MR services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months dropping any leftover portion) determined by dividing the total uncompensated value of the asset by the average monthly cost ~~($2,000)~~ to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one

year prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization;

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer;

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance;

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child;

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value;

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65; or

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for NF, ICF/MR, HCBW/MR, or ADvantage waiver services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(~~5~~6) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an ICF/MR or receiving HCBW/MR services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period

for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purpose of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty 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.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant 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.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services or HCBW for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(~~6~~7) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

## PART 9. CERTIFICATION, REDETERMINATION AND NOTIFICATION

### 317:35-9-75. Certification for long-term medical care through ICF/MR, HCBW/MR services and to persons age 65 and older in a mental health hospital

(a) **Application date.** If the applicant is found eligible for Medicaid, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months. The first month of the certification period must be the first month that medical service was provided and the recipient was determined eligible. An applicant approved for long-term medical care under Medicaid as categorically needy is mailed a permanent Medical Identification Card.

(b) **Certification period for long-term medical care.** A certification period of 12 months is assigned for an individual ~~categorically related to ABD~~ who is approved for long-term care. ~~When the individual determined eligible for long-term medical care is categorically related to AFDC, a certification period of 12 months is assigned.~~

## SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

## PART 3. RESOURCES

### 317:35-10-10. Capital resources

Capital resources are disregarded for individuals ~~categorically~~ related to ~~AFDC~~the children, parent and caretaker relative, former foster care children, SoonerPlan, or ~~Pregnancy~~pregnancy eligibility groups, including pregnancies covered under Title XXI. Prior to January 1, 2014, ~~The~~the countable income generated from any resource is considered in accordance with Part 5 of this ~~subchapter~~Subchapter. Effective January 1, 2014, countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

## PART 5. INCOME

**317:35-10-25. Income defined**

Prior to January 1, 2014, ~~Income~~income is defined as that gain, payment or proceed from labor, business, property, retirement and other benefits. Effective January 1, 2014, for MAGI eligibility groups as defined in OAC 317:35-6-1, income is defined by the Internal Revenue Code.

**317:35-10-26. Income**

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to ~~AFDC~~the children, parent or caretaker relative, SoonerPlan, or ~~Pregnancy~~Title XIX and XXI pregnancy eligibility groups does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Health Care Authority (OHCA). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 10 days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. Effective January 1, 2014, the MAGI methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in OAC 317:35-6-1.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Employment Securities Commission, then pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within 10 days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Prior to January 1, 2014, ~~A~~a nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to ~~an AFDC or~~a member of the children, parent or caretaker relative, or pregnancy ~~related recipient~~groups who is not currently eligible for SSI, is not counted as income. Effective January 1, 2014, whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Prior to January 1, 2014, ~~Lump~~lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award. Effective January 1, 2014, whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. Effective January 1, 2014, income received by a stepparent is considered in accordance with MAGI household and income counting rules.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six months, will be averaged and considered as income for the next six months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Effective January 1, 2014, whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two months to establish the amount to be anticipated and considered for prospective budgeting.

(6) Prior to January 1, 2014, ~~A~~a caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. Effective January 1, 2014, MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) Prior to January 1, 2014, ~~Consideration~~consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children. However, if that person is the stepparent, the policy on stepparent liability is applicable. Effective January 1, 2014, MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) Prior to January 1, 2014, ~~If~~if a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month. Effective January 1, 2014, MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) Prior to January 1, 2014, ~~A~~a stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included. Effective January 1, 2014, a stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) Prior to January 1, 2014, ~~When~~when there is a stepparent or person living in the home with the biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind. Effective January 1, 2014, MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages,

salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Prior to January 1, 2014, ~~Payments~~payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the wage prior to payroll deductions and/or withholdings. Effective January 1, 2014, whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(1) **Earned income from self-employment prior to January 1, 2014.** If the income results from the individual's activities primarily as a result of the individual's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

(iii) Self-employment income which represents an annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(B) **Items not considered.** The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from self-employment effective January 1, 2014.** For MAGI eligibility groups, the calculation of countable self-employment income is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(~~2~~3) **Earned income from wages, salary or commission.** Prior to January 1, 2014, ~~If~~if the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. 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 any other earned income. Effective January 1, 2014, countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(~~3~~4) **Earned income from work and training programs.** Prior to January 1, 2014, ~~Earned~~earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year. Effective January 1, 2014, countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(~~4~~5) **Individual earned income exemptions prior to January 1, 2014.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.

(A) **Work related expenses.** 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.

(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.

(i) Child care expense may be deducted when:

(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and

(II) the employed member whose income is considered must purchase care.

(ii) The actual amount paid for child care per month, up to a maximum of $200 for a child under the age of two or $175 for a child age two or older may be deducted.

(iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider.

(iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.

(v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(6) **No individual earned income exemptions effective January 1, 2014.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of 5% of the FPL for the individual's household size as defined in OAC 317:35-6-39.

(~~5~~7) **Formula for determining the individual's net earned income prior to January 1, 2014.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(8) **Formula for determining the individual's net earned income effective January 1, 2014 for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income prior to January 1, 2014.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(d) **Unearned income effective January 1, 2014.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(~~d~~e) **Income disregards prior to January 1, 2014.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

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

(3) Education Grants (including 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 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 was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. 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 the 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;

(5) Indian payments (including judgment funds or funds held in trust) which are distributed by the Secretary of the Interior (BIA) or distributed 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 judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. 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 petition in writing from trust funds of the student;

(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;

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

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

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

(12) 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;

(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;

(14) 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;

(15) Earnings of a child who is a full-time student are disregarded;

(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;

(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;

(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;

(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;

(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;

(21) 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.);

(22) 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;

(23) 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;
(24) Interests of individual Indians in trust or restricted lands;
(25) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);
(26) Any payments made directly to a third party for the benefit of a member of the benefit group;
(27) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;
(28) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complimentary payments;
(29) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(30) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);
(31) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(32) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
(33) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and
(34) Wages paid by the Census Bureau for temporary employment related to Census activities.

(f) **Income disregards effective January 1, 2014.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(~~e~~g) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.
(2) **Weekly.** Income received weekly is multiplied by 4.3.
(3) **Twice a month.** Income received twice a month is multiplied by 2.
(4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

## SUBCHAPTER 13. MEMBER RIGHTS AND RESPONSIBILITIES

### 317:35-13-1. Civil rights

A person shall not be denied Title XIX or Title XXI benefits or be subjected to discrimination on grounds of race, color, national origin, sex, age or handicap.

### 317:35-13-2. Courteous and prompt action

(a) **Courteous treatment.** It is the responsibility of the staff members of the Agency to be courteous and equitable in their dealings with all persons applying for and receiving medical services through the Medical Assistance program.
(b) **Prompt action.** Eligibility determination for Title XIX benefits is to be completed within ~~45 days of the date of application for persons categorically related to AA, AB or AFDC and within~~ 60 days of the date of application for persons ~~categorically~~ related to ~~AD~~the disabled group, and within 45 days of the date of application for individuals related to all other eligibility groups.

## SUBCHAPTER 15. PERSONAL CARE SERVICES

### 317:35-15-5. General financial eligibility requirements for Personal Care

Financial eligibility for Personal Care is determined using the rules on income and resources according to the ~~category~~eligibility group 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.)~~ Income and resources are evaluated on a monthly basis for all individuals requesting payment for Personal Care who are categorically related to ABD; maximum countable monthly income and resource standards for individuals related to ABD are found on OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP program standards).

### 317:35-15-6. Determining financial eligibility of categorically needy individuals

Financial eligibility for Personal Care for categorically needy individuals is determined as follows:

(1) **Financial eligibility/categorically related to AFDC prior to January 1, 2014.** In determining income for the individual related to AFDC, all family income is considered. (See OAC 317:35-5-45 for Exceptions to AFDC rules.) The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(A) spouse; and

(B) parent(s) and minor children of their own.

(i) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule X.

(ii) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule I. A.

(2) **Financial eligibility for MAGI eligibility groups effective January 1, 2014.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

(~~2~~3) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income must be less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP standard). If an individual and spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or HCBW/MR services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered.

(~~3~~4) **Determining financial eligibility for Personal Care.** For individuals determined categorically needy for Personal Care, the member will not pay a vendor payment for Personal Care services.

**317:35-15-7. Certification for Personal Care**

(a) The first month of the Personal Care certification period must be the first month the member was determined eligible for Personal Care, both financially and medically.

(1) As soon as eligibility or ineligibility for Personal Care is established, the local office updates the computer form and the appropriate notice is computer generated. Notice information is retained on the notice file for county use.

(2) An applicant approved for Personal Care under SoonerCare as categorically needy is mailed a Medical Identification Card.

(b) A medical certification period of not more than 36 months is assigned for an individual ~~categorically related to ABD~~ who is approved for Personal Care. The certification period for Personal Care is based on the UCAT evaluation and clinical judgment of the OKDHS area nurse or designee. ~~When the individual determined eligible for Personal Care is categorically related to AFDC, a medical certification period of not more than 36 months is assigned.~~

## SUBCHAPTER 19. NURSING FACILITY SERVICES

**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~~eligibility group 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 OKDHS Appendix C-1, Schedule VIII. B. 1., refer to OAC 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 SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins.

(b) **Financial eligibility for skilled nursing.** Skilled Nursing Care is covered as part of the Medicare Part A coverage. For members who are currently receiving this benefit through the QMB program, no further action is needed. For individuals who do not have an active SoonerCare case, an application is processed to receive the Medicare crossover and deductible benefits. Income eligibility is based on the categorically needy standard in 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 OKDHS Appendix C-1, Schedule VIII. B. 1.

(1) QMB eligible individuals in skilled nursing care are allowed the resource standard as shown on OKDHS Appendix C-1, Schedule VI, but must meet the SoonerCare resource standard as shown on OKDHS Appendix C-1, Schedule VIII. D., for NF level of care. For individuals with no active case, use the resource standard shown on OKDHS Appendix C-1, Schedule VIII. D.

(2) Rules concerning transfer of assets do not apply to skilled level of care.

**317:35-19-20. Determining financial eligibility of categorically needy individuals**

Financial eligibility for NF medical care is determined as follows:

(1) **Financial eligibility/categorically related to AFDC prior to January 1, 2014.**

(A) In determining income for the individual related to AFDC, all family income is considered. The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(i) spouse; and

(ii) parent(s) and minor children of their own.

(I) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule X.

(II) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule I. A.

(B) Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.

(2) **Financial eligibility for MAGI eligibility groups effective January 1, 2014.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

(~~2~~3) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering a nursing facility, see paragraph (3) of OAC 317:35-19-21 to determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI., is applicable for individuals related to ABD. If the individual is in an NF and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B.1., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard in OKDHS Appendix C-1, Schedule VI., is used. The rules on determination of income and resources are applicable only when an individual has entered a 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.

(B) An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

(~~3~~4) **Transfer of capital resources on or before August 10, 1993.** Individuals who have transferred capital resources on or before August 10, 1993 and applying for or receiving NF, ICF/MR, or receiving HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this policy. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost ~~($2,000)~~ to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

(A) However, the penalty would not apply if:

(i) The transfer was prior to July 1, 1988.

(ii) The title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.

(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(iv) The transfer was to the community spouse or to another person for the sole benefit of the

community spouse in an amount equal to the community spouse's resource allowance.

(v) The resource was transferred to the individual's minor child who is blind or totally disabled.

(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(B) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual.

(D) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored resource or the amount of commensurate return.

(E) The restoration or commensurate return will not entitle the member to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, ICF/MR, HCBW/MR, or ADvantage waiver services for a period of resource ineligibility.

(~~4~~5) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an NF.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ~~($2,000)~~ to a private patient in a nursing facility in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined

by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(~~5~~6) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an NF.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an

amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty 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.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant 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.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is redetermined considering the

value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(~~6~~7) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

**317:35-19-22. Certification for NF**

(a) **Application date.** The date of the application for NF care is most important in determining the date of eligibility. If the applicant is found eligible for Medicaid, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months. An applicant approved for long-term medical care under Medicaid as categorically needy is mailed a Medical Identification Card.

(b) **Time limited approvals for nursing care.** A medical certification period of a specific length may be assigned for an individual who is categorically related to ABD or AFDC. This time limit is noted on the system. It is the responsibility of the nursing facility to notify the area nurse 30 days prior to the end of the certification period if an extension of approval is required by the client. Based on the information from the NF the area nurse, or nurse designee, determines whether or not an update of the UCAT is necessary for the extension. The area nurse, or nurse designee, coordinates with appropriate staff for any request for further UCAT assessments.

(c) **Certification period for long-term medical care.** A financial certification period of 12 months is assigned for an individual ~~categorically related to ABD~~ who is approved for long-term care. ~~When the individual determined eligible for long-term medical care is categorically related to AFDC, a certification period of 12 months is assigned.~~

## SUBCHAPTER 21. OKLAHOMA CARES BREAST AND CERVICAL CANCER TREATMENT PROGRAM

**317:35-21-13. Redetermination**

A periodic redetermination of eligibility is required every 12 months. The computer generated redetermination form is mailed to the woman during her 11th month of eligibility. The woman ~~must provide a statement of current household income, and~~ is responsible for having her SoonerCare provider complete the statement certifying that she continues to be in need of treatment and for providing any other information necessary to redetermine eligibility.

(1) If the completed forms are not returned, the case is closed and appropriate notice is computer generated.

(2) When the completed forms are returned timely and the woman remains eligible for the BCC program, the computer is updated to show her continued eligibility.

*[OAR Docket #13-861; filed 5-21-13]*

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

*[OAR Docket #13-838]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Coverage and Exclusions
317:35-3-2. [AMENDED]
**(Reference APA WF # 12-23B)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes
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**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
**Final adoption:**
May 14, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
SoonerCare transportation and subsistence rules are revised to clarify OHCA's current policy concerning meals and lodging, and eligibility. Proposed revisions include eligibility requirements for escorts if SoonerCare member is removed from his/her home and appointed a temporary guardian.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

### 317:35-3-2. SoonerCare transportation and subsistence

(a) The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries(QMB)when SoonerCare pays only the Medicare premium, deductible, and co-pay;

(2) Specified Low Income Medicare Beneficiaries (SLMB);

(3) Qualifying Individuals-1;

(4) individuals who are in an institution for mental disease (IMD);

(5) inpatient;

(6) institutionalized(i.e. long-term care facility);

(7) Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children, the ADvantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide makes arrangements for the most appropriate, least costly transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision is final.

(1) **Authorization for transportation by private vehicle or bus.** Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) **Authorization for transportation by taxi.** Taxi service may be authorized at the discretion of the broker.

(3) **Transportation by ambulance (ground, air ambulance or helicopter).** Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(5) **Subsistence (~~sleeping accommodations~~lodging and meals).** ~~Lodging~~Payment for lodging and/or meals assistance for an eligible ~~members~~member and/or an approved medical escort is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. ~~All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking reimbursement for lodging.~~The member and/or medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA) has discretion and final

authority to approve or deny any lodging and/or meal services.

(A) Lodging and/or meals are reimbursable when prior ~~authorized.~~approved. Payment for lodging and/or meals is limited to a period of up to 24 hours prior to the start of the member's medical services and up to 24 hours after the services end. Lodging is approved for the member and/or one approved medical escort. The following factors may be considered by OHCA when ~~authorizing~~approving reimbursement for a member and/or one medical escort:

(i) travel is to obtain specialty care; and

(ii) the trip cannot be completed during SoonerRide operating hours;

(iii) the trip is ~~more than~~ 100 miles or more from the member's ~~city of~~ residence~~;~~, as listed in the OHCA system, to the medical facility; and/or

(iv) the member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.

(B) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(C) Meals will be reimbursed only if ~~an overnight stay occurs and the stay meets~~ the lodging criteria is met.

(D) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(E) During inpatient or outpatient medical stays, ~~meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days.~~lodging and/or meals services are reimbursed for a period of up to 14 days without prior approval; stays exceeding the 14 day period must be prior approved. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.

(F) For eligible members in the Neonatal Intensive Care Unit (NICU) a minimum visitation of 6 hours per day for the medical escort is required for reimbursement of lodging and/or meals services.

(~~F~~G) ~~A member who needs lodging and/or meal assistance must first seek services with an OHCA contracted lodging provider.~~Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be approved. If the lodging provider provides meals the member and/or medical escort is not eligible for separate reimbursement and may not seek assistance for meals obtained outside of the contracted ~~lodging facility.~~Room and Board provider facility. If lodging and/or meal assistance with contracted ~~lodging~~Room and Board providers is not available, the member and/or medical escort may request reimbursement assistance by submitting ~~a~~the appropriate travel reimbursement ~~form.~~forms. The travel reimbursement ~~form~~forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement ~~form~~forms must be documented with the required receipts~~,~~ and medical records to document the lodging and/or meals criteria have been met.~~reimbursement~~Reimbursement will not exceed established state per diem amounts. The OHCA has discretion and the final authority to approve or deny ~~meals and lodging~~lodging and/or meals reimbursement.

(6) **Escort assistance required.** Payment for transportation and ~~subsistence~~lodging and/or meals of one medical escort may be ~~authorized~~approved if the service is required. ~~Only one escort may be authorized.~~If the Oklahoma Department of Human Services (OKDHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for escort related lodging and/or meals services. The custodial parent, if under investigation, is not eligible. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health or disability does not permit traveling alone; and

(B) when the individual seeking medical services is a minor child.

*[OAR Docket #13-838; filed 5-21-13]*

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

*[OAR Docket #13-858]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41.6.[AMENDED]
**(Reference APA WF # 12-06)**
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The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1917 of the Social Security Act
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**SUPERSEDED EMERGENCY ACTIONS:**
**Superseded rules:**
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41.6. [AMENDED]
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
SoonerCare financial eligibility rules for Long Term Care services are amended to increase the income cap for the Medicaid Income Pension Trust (or Miller Trust) to the average monthly cost of nursing home care. This change affects financial eligibility rules for all long term care programs, including the waiver programs for Home and Community Based Services.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

## PART 5. COUNTABLE INCOME AND RESOURCES

### 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 12 O.S. 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 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 Schedule VIII.B) but less than ~~$3000~~the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(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~~cannot 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 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 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 and effective date 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 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.

*[OAR Docket #13-858; filed 5-21-13]*

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

*[OAR Docket #13-851]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 7. Determination of Financial Eligibility
317:35-9-68. [AMENDED]
Subchapter 19. Nursing Facility Services
317:35-19-21. [AMENDED]
**(Reference APA WF # 12-29)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1924 of the Social Security Act; 42 CFR 435.733
**DATES:**
**Comment period:**
February 1, 2013, through March 3, 2013
**Public hearing:**
March 4, 2013
**Adoption:**
March 14, 2013
**Submitted to Governor:**
March 14, 2013
**Submitted to House:**
March 14, 2013
**Submitted to Senate:**
March 14, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
**Final adoption:**
May 14, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Rules are amended to clarify that a member receiving Home and Community Based Services (HCBS) (such as ADvantage) is considered a community spouse for the purpose of calculating the community spouse allowance when his/her spouse is in a nursing facility. This amendment brings the rules into compliance with Federal law and regulation and the State Plan. It allows the spouse in the nursing facility to deem income to the spouse who remains at home, regardless of whether that spouse is receiving HCBS, before the vendor payment owed to the nursing facility is calculated.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

## PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

**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 OKDHS Form 08AX001E (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 SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 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~~his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (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 SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(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 for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. 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 OKDHS Form 08AX001E (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 SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 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 resource standard for an individual listed in OKDHS Form 08AX001E (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 SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(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 OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 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. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the ICF/MR, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 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 OKDHS Appendix C-1, Section XI.

(iii) The minimum resource standard for the community spouse 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 SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of 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 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 resource standard for an individual as shown in OKDHS Form 08AX001E (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 SoonerCare application for ICF/MR.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance 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 SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(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) **Determination of the vendor payment for ICF/MR.** Calculation of the vendor payment after financial eligibility for care in an ICF/MR has been established is determined according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/MR services are considered community spouses.

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

(A) Countable income;

(B) Minus the institutional or own home standard; and

(C) Minus the verified countable medical expenses (only the actual monthly payments being made for

medical insurance premiums including Medicare premiums).

(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two. This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:

(A) Determine the institutionalized spouse's monthly income as described in (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than one dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

(~~b~~c) **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~~d) **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 19. NURSING FACILITY SERVICES

### 317:35-19-21. Determining financial eligibility for care in NF

(a) 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 OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for NF services. If the individual's

gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 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 OKDHS Form 08AX001E (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 SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(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 for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. 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 OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ~~ADvantage~~Nursing Facility services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 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 resource standard for an individual listed in OKDHS Form 08AX001E (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 SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(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 OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 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. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the NF, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 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 OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS Form 08AX001E (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 SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of 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 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 resource standard for an individual as shown in OKDHS Form 08AX001E (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 SoonerCare application for NF.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance 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~~do 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 SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(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) Calculation of the vendor payment after financial eligibility for care in a NF has been determined is performed according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/MR services are considered community spouses.

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

(A) Countable income;

(B) Minus the institutional or own home standard; and

(C) Minus the verified countable medical expenses (only the actual monthly payments being made for medical insurance premiums including Medicare premiums).

(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two. This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:

(A) Determine the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than one dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in Subparagraph (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

*[OAR Docket #13-851; filed 5-21-13]*

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

*[OAR Docket #13-841]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 15. Personal Care Services
317:35-15-8. [AMENDED]
317:35-15-13.2. [AMENDED]
**(Reference APA WF # 12-34)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes; The Long Term Care Security Act, Sections 1-1944 through 1-1949 of the Oklahoma Statutes
**DATES:**
**Comment period:**
February 1, 2013, through March 3, 2013
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March 4, 2013
**Adoption:**
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March 14, 2013
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**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
**Final adoption:**
May 14, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Rules for State Plan Personal Care are revised to clarify compliance with the Long Term Care Security Act regarding background checks for providers of long term care services. Personal Care is assistance to a qualifying SoonerCare member in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry or errands directly related to the member's personal care needs. Personal Care is provided to assure personal health and safety of the member or to prevent or minimize physical health regression or deterioration. Background checks are required for all Personal Care providers prior to the provision of services.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 15. PERSONAL CARE SERVICES

### 317:35-15-8. Agency Personal Care Service Authorization and Monitoring

(a) Within ten working days of receipt of the referral for Personal Care services, the Personal Care Assessment/Service Planning Nurse completes a Service Authorization Model (SAM) visit in the home to assess the member's Personal Care service needs, completes a Service Authorization Model (SAM) packet based on the member's needs and submits the packet to the OKDHS nurse. The member's Service Authorization Model (SAM) packet includes:

(1) State Plan Personal Care Progress Notes (OKDHS form 02AG044E);

(2) Personal Care Planning Schedule [OKDHS form 02AG030E (AG-5)];

(3) Personal Care Plan [OKDHS form 02AG029E (AG-4)]; and

(4) Personal Care Service Plan [02AG031E (AG-6)].

(b) If more than one person in the household has been referred to receive Personal Care services, all household members' Service Authorization Model (SAM) packets are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of Personal Care service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.

(c) The Personal Care service agency receives a certified Service Plan [OKDHS form 02AG031E (AG-6)] from OKDHS as authorization to begin services. The agency delivers a copy of the care plan and service plan to the member upon initiating services.

(d) Prior to placing a Personal Care attendant in the member's home or other service-delivery setting, an OSBI background check, ~~OKDHS Community Service Worker Registry check in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and as appropriate, the Certified Nurse Aide Registry Check~~and registry check must be completed in accordance with Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes.

(e) The Personal Care Assessment/Service Planning Nurse monitors their member's plan of care.

(1) The Personal Care service provider agency contacts the member within five ~~calendar~~ working days of receipt of the approved care Service Plan [OKDHS form 02AG031E (AG-6)] in order to make sure that services have been implemented and the needs of the member are being met.

(2) The Personal Care Assessment/Service Planning Nurse makes a Service Authorization Model (SAM) home visit at least every ~~180 days~~six months to assess the member's satisfaction with their care and to evaluate the Service Authorization Model (SAM) packet for adequacy of goals and units authorized. Whenever a home visit is made, the Personal Care Assessment/Service Planning Nurse documents their findings in the State Plan Personal Care Progress Notes (OKDHS form 02AG044E). The personal care agency forwards a copy of the Progress Notes to the OKDHS nurse for review. The monitoring visit may be conducted by an LPN. If an LPN or social worker conducts the monitoring visit, an RN must co-sign the progress notes.

(3) Requests by the Personal Care service agency to change the number of units authorized in the Service Authorization Model (SAM) packet are submitted to OKDHS and are approved or denied by the OKDHS area nurse, or designee prior to implementation of the changed number of units.

(4) Annually, or more frequently if the member's needs change, the Personal Care Assessment/Service Planning Nurse re-assesses member's need and develops a new Service Authorization Model (SAM) eligibility packet to meet personal care needs.

(5) If the member is unstaffed, the Personal Care service agency communicates with the member and makes efforts to restaff. If the member is unstaffed for 30 calendar days, the agency notifies the OKDHS nurse on an OKDHS form 02AG032E (AG-7), Provider Communication Form. The OKDHS nurse contacts the member and if the member chooses, initiates a transfer of the member to another Personal Care service agency that can provide staff.

**317:35-15-13.2. Individual Personal Care contractor; billing, training, and problem resolution**

While OHCA is the contractor authorized under federal law, the Oklahoma Department of Human Services (OKDHS) initiates initial contracts with qualified individuals for provision of Personal Care services as defined in OAC 317:35-15-2. The contract renewal for the PCA is the responsibility of the Oklahoma Health Care Authority (OHCA).

(1) **Payment for Personal Care.** Payment for Personal Care is generally made for care in the member's own home. A rented apartment, room or shelter shared with others is considered "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home. Personal Care may not be approved if the member lives in the PCA's home except with the interdisciplinary team's written approval. The potential individual PCA must meet the minimum requirements under (2) of this subsection. With OKDHS area nurse approval, or for ADvantage waiver members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the service plan.

(A) **Reimbursement.** Personal Care payment for a member is made according to the number of units of service identified in the service plan.

(i) The unit amounts paid to individual contractors is according to the established rates. A service plan will be developed for each eligible individual in the home and units of service assigned to meet the needs of each member. The service plans will combine units in the most efficient manner to meet the needs of all eligible persons in the household.

(ii) From the total amounts billed by the individual PCA in (i) of this subparagraph, the OHCA (acting as agent for the member-employer) withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To assure that the individual contractor's social security account may be properly credited, it is vital that the individual contractor's social security number be entered correctly on each claim. In order for the OHCA to withhold FICA tax, the LTC nurse must obtain a signed OHCA Form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, from the member as soon as the area nurse, or designee, has approved Personal Care. A copy of the signed HCA-66 must be in the case record. A signed OHCA-0026, Personal Care Program Individual Contract, must be on file with the OHCA before

the individual contractor's first claim can be submitted.

(iii) The contractor payment fee covers all Personal Care services included on the service and care plans developed by the LTC nurse or ADvantage case manager. Payment is made for direct services and care of the eligible member(s) only. The area nurse, or designee, authorizes the number of units of service the member receives each month.

(iv) A member may select more than one individual contractor. This may be necessary as indicated by the service and care plans.

(v) The individual contractor may provide SoonerCare Personal Care services for several households during one week, as long as the daily number of paid service units do not exceed eight per day. The total number of hours per week cannot exceed 40.

(B) **Release of wage and/or employment information for individual contractors.** Any inquiry received by the local office requesting wage and/or employment information for an individual Personal Care contractor will be forwarded to the OHCA, Claims Resolution.

(2) **Member selection of individual PCA.** Members and/or family members recruit, interview, conduct reference checks, and select the individual to be considered as an individual contractor. ~~An individual contractor applicant must have a background check performed by the Oklahoma State Bureau of Investigation (OSBI). The results of the background check determine whether a person will be permitted to work as an individual Personal Care contractor. According to Section 1025.2 of Title 56 of the Oklahoma Statutes, before the member employer makes an offer to employ or contract with a SoonerCare Personal Care Assistant applicant to provide Personal Care Services to a person who receives SoonerCare Personal Care Services, the OKDHS LTC nurse, acting for the member, must check the OKDHS Community Services Worker Registry to determine if the name of the applicant seeking employment or contract has been entered.~~Prior to placing a Personal Care service provider in the member's home, an OSBI background check and registry check must be completed in accordance with Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. The OKDHS LTC nurse must also check the Certified Nurse Aid Registry. The OKDHS LTC nurse must affirm that the applicant's name is not contained on ~~either registry~~ any of the registries. The LTC nurse will notify the OHCA if the applicant is on the registry.

(A) **Persons eligible to serve as individual Personal Care Assistants.** Payment is made for Personal Care Services to an individual who:

(i) is at least 18 years of age,

(ii) has no pending notation related to abuse, neglect or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry,

~~(iii) is not included on the OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56, of Oklahoma Statutes,~~

~~(iv) has not been convicted of a crime as outlined in Title 63 of Oklahoma Statutes, Sections 1-1950 as determined by an OSBI background check,~~

(iii) has no criminal background history or registry listings that prohibit employment,

(~~v~~iv) demonstrates the ability to understand and carry out assigned tasks,

(~~vi~~v) is not a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the member beingserved,

(~~vii~~vi) has a verifiable work history and/or personal references, verifiable identification, and

(~~viii~~vii) meets any additional requirements as outlined in the contract and certification requirements with the Oklahoma Health Care Authority.

(B) **Persons ineligible to serve as Personal Care Assistants.** Payment from SoonerCare funds for Personal Care services may not be made to an individual who is a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the member to whom he/she is providing personal care services.

(i) Payment cannot be made to a OKDHS or OHCA employee. Payment cannot be made to an immediate family member of an OKDHS employee who works in the same county without OKDHS/Aging Services Division approval. When a family member relationship exists between an OKDHS LTC nurse and a PCA in the same county, the LTC nurse cannot manage services for a member whose individual provider is a family member of the LTC nurse.

(ii) If it is determined that an employee is interfering in the process of providing Personal Care Services for personal or family benefit, he/she will be subject to disciplinary action.

(3) **Orientation of the Personal Care Assistant.** When a member selects an individual PCA, the LTC nurse contacts the individual to report to the county office to complete the ODH form 805, Uniform Employment Application for Nurse Aide Staff, and the OKDHS form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. This process is the responsibility of the LTC nurse. The PCA can begin work when:

(A) he/she has been interviewed by the member,

(B) he/she has been oriented by the LTC nurse,

(C) he/she has executed a contract (OHCA-0026) with the OHCA,

(D) the effective service date has been established,

(E) ~~the Community Service Worker Registry has been~~all registries have been checked and the PCA's name is not ~~on the Registry~~listed,

(F) the Oklahoma State Department of Health Nurse Aide Registry has been checked and no notations found, and

(G) the OSBI background check has been completed.

(4) **Training of Personal Care Assistants.** It is the responsibility of the LTC nurse to make sure for each client, that the PCA has the training needed to carry out the plan of care prior to service initiation.

(5) **Problem resolution related to the performance of the Personal Care Assistant.** When it comes to the attention of the LTC nurse or worker that there is a problem related to the performance of the PCA, a counseling conference is held between the member, LTC nurse and worker. The LTC nurse will counsel the PCA regarding problems with his/her performance. Counseling is considered when the staff believe that counseling will result in improved performance.

(6) **Termination of the PCA Provider Agreement.**

(A) A recommendation for the termination of a PCA's contract is submitted to the OHCA and the services of the PCA are suspended immediately when:

(i) a PCA's performance is such that his/her continued participation in the program could pose a threat to the health and safety of the member or others; or

(ii) the PCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or has not been effective; or

(iii) a PCA's name appears on ~~the OKDHS Community Services Worker Registry,~~any of the registries listed in Section 1-1947 of Title 63 of the Oklahoma Statutes, even though his/her name may not have appeared on the Registry at the time of application or hiring.

(B) The LTC nurse makes the recommendation for the termination of the PCA to the OKDHS State Office Aging Services Division who then notifies the OHCA Legal Division of the recommendation. When the problem is related to allegations of abuse, neglect, or exploitation, OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, the OHCA, and the Oklahoma State Department of Health are notified by the LTC nurse.

(C) When the problem is related to allegations of abuse, neglect or exploitation, the LTC nurse follows the process as outlined in OAC 340:100-3-39.

*[OAR Docket #13-841; filed 5-21-13]*

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

*[OAR Docket #13-859]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 17. ADvantage Waiver Services
317:35-17-3. [AMENDED]
317:35-17-14. [AMENDED]
**(Reference APA WF # 12-04B)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Sections 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act
**DATES:**
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April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
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July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
OHCA rules for the ADvantage Waiver are revised to add Skilled Nursing as an allowable service within the waiver. Currently Skilled Nursing services are only available as a part of the member's limited home health benefit. The addition of Skilled Nursing services will be used to address member acute care needs, potentially lowering the rate of hospitalization among members. Finally, rules are revised to clarify criteria for member health and safety, clarify the member/provider dispute resolution process and include other minor policy clarifications.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

**317:35-17-3. ADvantage program services**

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance non-institutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain ~~Mediciad~~Medicaid eligibility. Eligibility for ADvantage is contingent on an individual requiring one or more of the services offered in the waiver at least monthly in order to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if age 21 or older and not physically disabled, the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have intellectual disability or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following criteria:

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(f)]; and

(C) meet program eligibility criteria [see 317:35-17-3(g)].

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth below.

(1) ADvantage program members are not eligible to receive services while residing in an institutional setting, including but not limited to licensed facilities such as a hospital, a nursing facility, a licensed residential care facility, or a licensed assisted living facility, (unless the facility is an ADvantage Assisted Living Center), or in an unlicensed institutional living arrangement such as a room and board home/facility.

(2) ADvantage program members may receive services in a contracted ADvantage Assisted Living Center; an ADvantage Assisted Living Center is the only housing-with-nursing-supervised personal care services option in which a person may appropriately receive ADvantage services.

(3) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment or independent living apartment or a family or friend's home or apartment. A home/apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(4) ADvantage program members may receive services in a shelter or similar temporary housing arrangement which may or may not meet the definition of home/apartment, in emergency situations, for a period not to exceed sixty (60) days during which location and transition to permanent housing is being sought.

(5) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services for the period during which the member is a student.

(6) Members may receive ADvantage respite services in a nursing facility for a continuous period not to exceed thirty (30) days.

(d) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. ~~If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap.~~

(e) Services provided through the ADvantage waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy/occupational therapy/speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) nursing;

(9) skilled nursing;

(~~9~~10) home delivered meals;

(~~10~~11) hospice care;

(~~11~~12) medically necessary prescription drugs within the limits of the waiver;

(~~12~~13) personal care (state plan) or ADvantage personal care;

(~~13~~14) Personal Emergency Response System (PERS);

(~~14~~15) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(~~15~~16) Institution Transition Services;

(~~16~~17) assisted living; and

(~~17~~18) SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

(f) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as an open slot becomes available.

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have intellectual disability or a cognitive impairment.

(3) the individual is not eligible if he/she poses a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(5) the individual is not eligible if his/her living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or not feasible.

(g) The State, as part of the waiver program approval authorization, assures CMS that each member's health, safety or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured. The AA determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on the following criteria:

(1) the individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) the individual members of the individual's household, and/or the conditions of the living environment itself,~~poses~~pose a physical threat to self or others as supported by professional documentation and measures to correct conditions are unsuccessful, or are not feasible.

(3) ~~other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors~~the individual or other household members use threatening, intimidating, degrading, or sexually inappropriate language/innuendo or behavior towards service providers, either in the home or through other contact or communications, and significant efforts have been attempted to correct such behavior, as supported by professional documentation.

(4) ~~after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.~~the individual or the individual's authorized agent is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in their home, as determined by the individual, the interdisciplinary team, or the AA.

(5) the individual's living environment poses a physical threat to self or others as supported by professional documentation, where applicable and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) ~~the individual's health safety or welfare in their home cannot be assured due to continued refusal of planned services.~~the individual provides false or materially inaccurate information that is necessary to determine program eligibility, or withholds information that is necessary to determine program eligibility.

(7) the individual does not require at least one ADvantage service monthly.

(h) The case manager provides the AA with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.

(i) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

~~(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.~~

**317:35-17-14. Case management services**

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to

the member. The case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and OKDHS in the program), review, update and complete the UCAT assessment, discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's UCAT identified primary physician that the member has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 14 calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an individualized care plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan. The care plan and service plan are based on the member's service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. If in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the care plan the presence of two or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the IVRA system in the member record any instance in which a member's health or safety would be "at risk" if even one personal care visit is missed. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the OKDHS nurse or AA may identify members that require AA intervention<u>through referral to the AA's Escalated Issues unit</u>.

(A) For members that are uncooperative or disruptive, the case manager develops an individualized plan to overcome challenges to receiving services focusing on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and addenda that allow the member to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the member's signature when, for these members, the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the member from controlling their behavior to act in their own interest. Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may authorize the service plan if the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the care plan and service plan, the member may withdraw their request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination.

(A) The ADvantage Case Management provider assigns to the CD-PASS member a Case Manager that has successfully completed training on CD-PASS, Independent Living Philosophy, Person-Centered Planning and the individual budgeting process and process guidelines. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about their rights and responsibilities as well as about community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

(B) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the AA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide ~~Personal Services Assistance~~Consumer-Directed Personal Assistance Services and Supports (CD-PASS) services to a member may not be designated the "authorized representative" for the member.

(iii) The case manager reviews the designation of Authorized Representative, Power of Attorney and Legal Guardian status on an annual basis and this is included in the reassessment packet to AA.

(C) The CDA/CM provides support to the member in the Person-Centered CD-PASS Planning process. Principles of Person-Centered Planning are as follows:

(i) The person is the center of all planning activities.

(ii) The member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.

(v) Person-Centered Planning results in personally-defined outcomes.

(D) The CDA/CM encourages and supports the member, or as applicable their designated "authorized representative", to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/CM helps the member define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the member in translating the assessment of member needs and preferences into an individually tailored, personalized service plan.

(E) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization will be reduced proportional to agency Personal Care service utilization.

(F) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the service plan. The start date must be after authorization of services, after completion and approval of the background checks and after completion of the member employee packets.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) If the plan requires an APSA to provide assistance with Health Maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific Health Maintenance tasks safely and competently;

(i) If the member's APSA has been providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the PSA, additional documentation of competence is not required;

(ii) If the member and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

(I) The CDA/CM monitors the member's well being and the quality of supports and services and assists the member in revising the PSA services plan as needed. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDA/CM, based upon an updated assessment, amends the service plan to modify CD-PASS service units appropriate to meet additional member's need and forwards the plan amendment to the AA for authorization and update of the member's IBA.

~~(J) The CDA/CM uses the ADvantage Risk Management process the results of which are binding on all parties to resolve service planning or service delivery disagreements between members and ADvantage service providers under the following circumstances:~~

~~(i) A claim is formally registered with the CDA/CM by the member (or the member's family or "authorized representative"), the AA, or a provider that the disagreement poses a significant risk to the member's health or safety; and~~

~~(ii) The disagreement is about a service, or about the appropriate frequency, duration or other aspect of the service; or~~

~~(iii) The disagreement is about a behavior/action of the member, or about a behavior/action of the provider.~~

(J) In the event of a disagreement between the member and CD-PASS provider the following process is followed:

(i) either party may contact via a toll free number the Member/Provider Relations Resource Center to obtain assistance with issue resolution;

(ii) if the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program Management, the CD-PASS Program Management will submit the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit will work with the member and provider to reach a mutually agreed upon resolution;

(iii) if the dispute cannot be resolved by the ADvantage Escalated Issues Unit it will be heard by the Ethics of Care Committee. The Ethics of Care Committee will make a final determination with regard to settlement of the dispute;

(iv) at any step of this dispute resolution process the member may request a fair hearing, to appeal the dispute resolution decision.

(K) The CDA/CM and the member prepare an emergency backup/emergency response capability for CD-PASS PSA services in the event a PSA provider of services essential to the individual's health and welfare fails to deliver services. As part of the planning process, the CDA/CM and member define what failure of service or neglect of service tasks would constitute a risk to health and welfare to trigger implementation of the emergency backup. Any of the following may be used in planning for the backup:

(i) Identification of a qualified substitute provider of PSA services and preparation for their quick response to provide backup services when called upon in emergency circumstances (including execution of all qualifying background checks, training and employment processes); and/or,

(ii) Identification of one or more qualified substitute ADvantage agency service providers (Adult Day Care, Personal Care or Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called upon in emergency circumstances.

(L) If the emergency backup fails, the CDA/CM is to request the AA to authorize and facilitate member access to Adult Day Care, Agency Personal Care or Nursing Facility Respite services.

(5) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the AA are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.

(6) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the member to facilitate service plan implementation. ~~Within one working day of receipt of a copy or the computer-generated authorized service plan from the AA, the case manager sends (by mail or fax) copies of the authorized service plan or computer-generated copies to providers.~~ Within five working days of notification of an initial service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and

(B) monthly after the initial 30 day follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans.** The ADvantage Administration (AA) authorizes the individual service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized.

(1) Except as provided by the process described in OAC 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member (spouse or parent of a minor child).

(2) The OKDHS/ASD may under criteria described in OAC 317:35-15-13 authorize personal care service provision by an Individual PCA (an individual contracted

directly with OHCA). Legally responsible family members are not eligible to serve as Individual PCA's.

(3) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes or denies authorization within five working days of receipt of the request. If the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.

(4) The AA authorizes the service plan by entering the authorization date and assigning a control number that internally identifies the OKDHS staff completing the authorization. Notice of authorization and a computer-generated copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the authorization date. A service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within 5 working days.

(5) For audit purposes (including Program Integrity reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the member's case manager.

(c) **Change in service plan.** The process for initiating a change in the service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA within five calendar days of assessed need. The AA authorizes or denies the care plan and service plan changes per 317:35-17-14.

(2) The member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas in which CD-PASS services are available. The member may contact the AA or by calling the toll-free number established to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires an updated UCAT reassessment by the case manager. The case manager develops an amended or new service plan and care plan, as appropriate, and submits the new amended plans for authorization.

(4) One or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two or more ADvantage members residing in the same household, or

(B) the member and personal care provider residing together, or

(C) a request for a family member to be a paid ADvantage service provider, or

(D) a request for an Individual PCA service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the member's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care.

*[OAR Docket #13-859; filed 5-21-13]*

## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

*[OAR Docket #13-839]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Member Services
Part 1. Agency Companion Services
317:40-5-5. [AMENDED]
Part 5. Specialized Foster Care
317:40-5-55. [AMENDED]
317:40-5-61. [REVOKED]
**(Reference APA WF # 12-27)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Sections 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act
**DATES:**
**Comment period:**
February 1, 2013, through March 3, 2013
**Public hearing:**
March 4, 2013
**Adoption:**
March 14, 2013
**Submitted to Governor:**
March 14, 2013
**Submitted to House:**
March 14, 2013

**Submitted to Senate:**
March 14, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
**Final adoption:**
May 14, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Rules for SoonerCare Home and Community Based Waiver Services (HCBS) programs for persons with intellectual disabilities are amended to clarify responsibilities for Agency Companion providers and Specialized Foster Care providers regarding reporting requirements when there are allegations of member maltreatment. The rules clarify that the Office of Client Advocacy must be contacted in the event of allegations of maltreatment involving an adult and an abuse hotline must be utilized in the event that the maltreatment involves a child. Rules are also amended to clarify that the Agency Companion must obtain prior approval from the member's representative payee before making purchases over $50 on behalf of the member.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. MEMBER SERVICES

## PART 1. AGENCY COMPANION SERVICES

### 317:40-5-5. Agency Companion Services provider responsibilities

(a) Providers of Agency Companion Services (ACS) are required to meet all applicable standards outlined in this subchapter and competency-based training described in OAC 340:100-3-38. The provider agency ensures that all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and if warranted, revocation of approval of the companion.

(c) In addition to the criteria given in OAC 317:40-5-4, the companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, or friends without prior written authorization from the OKDHS Developmental Disabilities Services Division (DDSD) area manager or designee;

(2) meets the requirements of OAC 317:40-5-103, Transportation. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's enhanced independence, self sufficiency, community inclusion, and well-being;

(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan(Plan) for service provision;

(6) with assistance from the DDSD case manager and the provider agency program coordination staff, develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan;

(A) The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff.

(B) The agency staff provides monthly reports to the DDSD case manager or nurse.

(7) delivers services at appropriate times as directed in the Plan;

(8) does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);

(9) is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;

(10) participates in and supports visitation and contact with the member's natural family, guardian, and friends, provided this visitation is desired by the member;

(11) obtains permission from the member's legal guardian, if a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the member in any publicity;

(12) serves as the member's health care coordinator per OAC 340:100-5-26;

(13) ensures the monthly room and board contribution received from the member is used toward the cost of operating the household;

(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;

(15) works closely with the provider agency program coordination staff and the DDSD case manager to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;

(16) assists the member in achieving the member's maximum level of independence;
(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;
(18) ensures that the member's confidentiality is maintained per OAC 340:100-3-2;
(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) implements training and provides supports that enable the member to actively join in community life;
(21) does not serve as representative payee for the member without a written exception from the DDSD area manager or designee;
(A) The written exception is retained in the member's home record.
(B) When serving as payee, the companion complies with the requirements of OAC 340:100-3-4.
(22) ensures the member's funds are properly safeguarded.
(23) obtains prior approval from the ~~provider agency~~member's representative payee when making a purchase of over $50.00 with the member's funds;
(24) allows the provider agency staff and DDSD staff to make announced and unannounced visits to the home;
(25) develops an Evacuation Plan, using OKDHS Form 06AC020E, for the home and conducts training with the member;
(26) conducts fire and weather drills at least quarterly and documents the fire and weather drills using Form 06AC021E;
(27) develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using Form 06AC022E;
(28) supports the member's employment program by:
(A) assisting the member to wear appropriate work attire; and
(B) contacting the member's employer as outlined by the Team and in the Plan; and
(29) is responsible for the cost of their meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution~~.~~;
(30) for adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, and/or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes to the Office of Client Advocacy (OCA);
(31) for children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Abuse Hotline at 1-800-522-3511; and
(~~30~~32) follows all applicable rules promulgated by the Oklahoma Health Care Authority and DDSD, including:
(A) OAC 340:100-3-40;
(B) OAC 340:100-5-50 through 100-5-58;
(C) OAC 340:100-5-26;
(D) OAC 340:100-5-34;
(E) OAC 340:100-5-32;
(F) OAC 340:100-5-22.1;
(G) OAC 340:100-3-27; ~~and~~
(H) OAC 340:100-3-38~~.~~; and
(I) OAC 340:100-3-34;

## PART 5. SPECIALIZED FOSTER CARE

### 317:40-5-55. Specialized Foster Care provider responsibilities

(a) **General responsibilities.** The responsibilities of all Specialized Foster Care (SFC) providers are listed in this Section.
(1) Providers of SFC are required to meet all applicable standards per OAC 317:40-5-40.
(2) Providers of SFC are required to receive competency based training per OAC 340:100-3-38. The provider keeps all required training up to date and submits documentation to the SFC specialist at the time training is completed.
(3) The provider is an active participant of the member's Team and assists in the development of the member's Individual Plan (Plan) per OAC 340:100-5-50 through 100-5-58.
(4) The provider documents and notifies the case manager of any changes in behaviors or medical conditions of the member within one working day. Incident reports are completed by the SFC provider and submitted to the Developmental Disabilities Services Division (DDSD) case manager per OAC 340:100-3-34.
(5) The SFC provider is available to the member at any time.
(6) The primary responsibility of the SFC provider is to provide SFC services to the member. The SFC provider does not have employment unless the employment has been pre-approved by the residential programs supervisor for DDSD.
(A) Generally, providers are not approved for employment because the provider must be available before and after school or vocational programs and often during the day due to holidays or illnesses.
(B) If, after receiving approval for employment, it is found that the SFC provider's employment interferes with the care, training, or supervision needed by the member, the provider must determine if he or she wants to terminate the employment or have the member moved from the home.
(C) DDSD does not authorize Homemaker, Habilitation Training Specialist, or respite services in order for the SFC provider to perform employment.
(7) The provider does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals With Disabilities Education Act (IDEA-B).

(8) The provider allows the member to have experiences, both in and out of the home, to enhance the member's development, learning, growth, independence, community inclusion, and well-being, while assisting the member to achieve his or her maximum level of independence.

(9) The provider ensures confidentiality is maintained regarding the member per OAC 340:100-3-2.

(10) The provider is sensitive to and assists the member in participating in the member's choice of religious faith. No member is expected to attend any religious service against his or her wishes.

(11) The provider arranges, and ensures that the member obtains a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.

(12) The provider has a valid driver license, maintains a motor vehicle in working order, and complies with requirements of OAC 317:40-5-103, Transportation.

(13) The provider transports or arranges transportation, using adapted transportation when appropriate, for the member to and from school, employment, church, recreational activities, and medical or therapy appointments.

(A) SFC providers may enter into a transportation contract.

(B) The provider must assure availability and use of an approved and appropriate child auto restraint system as required by law in transporting children and, in cases of adults receiving services, any additional safety devices identified as necessary in the Plan.

(14) The provider assures the member is clean, appropriately dressed, and on time for activities and appointments.

(15) The provider ensures no other adult or child is cared for or resides in the home on a regular or part-time basis that was not approved through the home profile review process or without prior approval from the DDSD area manager or designee.

(16) The provider does not provide services to more than three individuals regardless of the type of service provided, including SFC, Children and Family Services Division foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the director of DDSD or designee prior to authorization or service delivery.

(17) The provider permits visitation and monitoring of the home by authorized DDSD staff. In order to assure maintenance of standards, some visits are unannounced. The visits occur at least monthly and are not intended to be intrusive but to ensure the safety and well-being of the member.

(18) The provider encourages and cooperates in planning visits in the SFC home by relatives, guardians, or friends of the member. Visits by the member to the home of friends or relatives must be approved by the member's legally authorized representative.

(19) The provider abides by the policies of DDSD per OAC 340:100-3-12, Prohibition of client abuse, and OAC 340:100-5-58, Prohibited procedures. The provider is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment.

(20) The provider notifies the DDSD case manager when the need arises for substitute supervision in the event of an emergency, in accordance with the Backup Plan, per OAC 317:40-5-59. If the provider is out of the home for a short duration, a natural support in the home can provide time-limited supervision.

(A) A natural support is defined as an adult relative or spouse of the specialized foster parent that resides in the home.

(B) The Team approves the natural support and defines when this support may be accessed.

(C) Persons who are considered a natural support must complete training per OAC 340:100-3-38.12.

(D) Persons acting as a natural support may only provide supervision for brief, intermittent time periods.

(21) The provider provides written 30-day notice to the member and DDSD case manager when it is necessary for a member to be moved from the home.

(22) The SFC provider does not serve as representative payee for the member.

(23) The provider ensures the member's funds are properly safeguarded.

(24) The provider assists the member in accessing and using entitlement programs for which the member may be eligible.

(25) The provider must use the room and board reimbursement payment to meet the member's needs, as specified in the room and board contract.

(A) The provider retains a copy of the current room and board contract in the home at all times.

(B) Items purchased with the room and board reimbursement include, but are not limited to:

(i) housing;

(ii) food;

(iii) clothing;

(iv) care;

(v) incidental expenses such as:

(I) birthday and Christmas gifts;

(II) haircuts;

(III) personal grooming equipment;

(IV) allowances;

(V) toys;

(VI) school supplies and lunches;

(VII) school pictures;

(VIII) costs of recreational activities;

(IX) special clothing items required for dress occasions and school classes such as gym shorts and shirts;

(X) extracurricular athletic and other equipment, including uniforms, needed for the member to pursue his or her particular interests or job;

(XI) prom and graduation expenses including caps, gowns, rings, pictures, and announcements;

(XII) routine transportation expenses involved in meeting the member's medical, educational, or recreational needs, unless the provider has a transportation contract;

(XIII) non-prescription medication; and

(XIV) other maintenance supplies required by the member.

(C) All items purchased for the member with the room and board payment are the property of the member and are given by the provider to the member when a change of residence occurs.

(D) The room and board payment is made on a monthly basis and is prorated based on the actual days the member is in the home on the initial and final months of residence.

(26) The provider maintains a Personal Possession Inventory Form 06AC022E (DDS-22) for each member living in the home.

(27) The provider maintains the member's home record per OAC 340:100-3-40.

(28) The provider immediately reports to the DDSD SFC staff all changes in the household including, but not limited to:

(A) telephone number;

(B) address;

(C) marriage or divorce;

(D) persons moving into or out of the home;

(E) provider's health status;

(F) provider's employment; and

(G) provider's income.

(29) The provider maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the SFC Specialist.

(30) The provider serves as the Health Care Coordinator and follows the Health Care Coordinator policy per OAC 340:100-5-26.

(31) Each SFC provider follows all applicable rules of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority, promotes the independence of the member, and follows recommendations of the member's Team.

(b) **Responsibilities specific to SFC providers serving children.** The provider is charged with the same general legal responsibility any parent has to exercise reasonable and prudent behavior in his or her actions and in the supervision and support of the child.

(1) The provider works with the DDSD case manager and CFSD staff when the provider needs respite for a child in custody.

(2) The provider participates in the development of the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate.

(3) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDSD case manager prior to traveling out of state for an overnight visit. If the child is in the custody of the OKDHS, the permission of the CFSD specialist is also secured.

(4) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDSD case manager prior to involvement of the child in any publicity. If the child is in OKDHS custody, the permission of the CFSD specialist is also secured.

(5) The provider reports any abuse, neglect, sexual abuse, or sexual exploitation of children per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Abuse Hotline at 1-800-522-3511.

(c) **Responsibilities specific to SFC providers serving adults.** Additional SFC provider responsibilities for serving adults are given in this Subsection.

(1) The provider obtains permission from the member's legal guardian, when applicable, and notifies the DDSD case manager, prior to:

(A) traveling out of state for an overnight visit.

(B) involvement of the member in any publicity.

(2) When the member is his or her own payee or has a representative payee, the provider ensures the monthly contribution for services as identified in a written agreement between the member and the provider, is used toward the cost of food, rent, and household expenses.

(A) The member's minimum monthly contribution is $250.00 per month.

(B) Changes in the member's monthly contribution are developed on an individualized basis by the member's Team.

(3) Reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, and/or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes to the Office of Client Advocacy (OCA).

**317:40-5-61. Investigations of alleged abuse or neglect of a service recipient in a specialized foster care home [REVOKED]**

~~Any referral regarding alleged abuse, neglect or exploitation of a service recipient is reported immediately to the appropriate investigative office.~~

~~(1) Allegations concerning children are reported to the Oklahoma Department of Human Services (OKDHS) Division of Children and Family Services (DCFS) office in accordance with OAC 340:75-1-9.~~

~~(2) Allegations concerning adults are reported to the OKDHS Adult Protective Services office as required by Section 10-104 of Title 43A of the Oklahoma Statutes.~~

~~(3) Allegations concerning a Homeward Bound class member are referred for investigation to the OKDHS Office of Client Advocacy.~~

*[OAR Docket #13-839; filed 5-21-13]*

# TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
# CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

*[OAR Docket #13-832]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Member Services
Part 9. Service Provisions
317:40-5-110. [AMENDED]
**(Reference APA WF # 12-01B)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act *The Hissom Memorial Center et al.*, in case number 85-CV-437-GKF, in the United States District Court for the Northern District of Oklahoma
**DATES:**
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Permanent rule revisions are proposed to provide an exception for members of the Homeward Bound Waiver receiving Habilitation Training Specialist (HTS) services. The rule revision will allow the HTS to provide more than 40 hours of service per week, when the HTS resides in the same home as the member. The rule revision is promulgated as the result of a lawsuit filed on behalf of class members of the Homeward Bound waiver.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. MEMEBER SERVICES

## PART 9. SERVICE PROVISIONS

### 317:40-5-110. Authorization for Habilitation Training Specialist Services

(a) Habilitation Training Specialist (HTS) Services are:

(1) authorized as a result of needs identified by the team and informed selection by the SoonerCare member;

(2) shared among SoonerCare members who are members of the same household or being served in the same community location;

(3) authorized only during periods when staff are engaged in purposeful activity which directly or indirectly benefits the service recipient. Staff must be physically able and mentally alert to carry out the duties of the job. At no time are HTS services authorized for periods during which the staff are allowed to sleep;

(4) not authorized to be provided in the home of the HTS unless the SoonerCare member and HTS reside in the same home; and

(5) directed toward the development or maintenance of a skill in order to achieve a specifically stated outcome. The service provided is not a function which the parent would provide for the individual without charge as a matter of course in the relationship among members of the nuclear family when the member resides in a family home.

(b) HTS Services may be provided in a group home as defined in 317:40-5-152 or community residential service settings defined in OAC 340:100-5-22.1 including:

(1) agency companion services as described in OAC 317:40-5-1 through 40-5-39;

(2) as provided in accordance with Daily Living Supports policy at OAC 317:40-5-150; and,

(3) as provided in accordance with Specialized Foster Care Policy at OAC 317:40-5-50 through 40-5-76; or

(4) services for people with Prader Willi syndrome.

(c) HTS Services are based on need and limited to no more than 12 hours per day per household in any setting other than settings described in OAC 340:100-5-22.1, Community Residential Supports, except with approval in accordance with OAC 340:100-3-33, Service authorization, that the increased services are necessary to avoid institutional placement due to:

(1) the complexity of the family or caregiver support needs. Consideration must be given to:

(A) the age and health of the caregiver;

(B) the number of household members requiring the caregiver's time; and

(C) the accessibility of needed resources; and

(2) the resources of the family, caregiver, or household members that are available to the service recipient. Consideration must be given to the number of family members able to assist the caregiver and available community supports; and

(3) the resources of other agencies or programs available to the SoonerCare member or family. Consideration must be given to services available from:

(A) the public schools;

(B) the Oklahoma Health Care Authority;

(C) the Oklahoma Department of Rehabilitative Services;

(D) other OKDHS programs; and

(E) services provided by other local, state, or federal resources.

(d) When it appears that approval of an exception is needed to prevent institutional placement, the case manager submits the request which identifies the circumstances supporting the need for an exception to the area manager.

(e) The DDSD area manager or designee must approve, deny, or notify the case manager of issues preventing approval within 10 working days.

(f) HTS providers may not perform any job duties associated with other employment, including on call duties, at the same time they are providing HTS services.

(g) HTS services are limited to no more than 40 hours per week when the HTS resides in the same home as the service recipient. If additional hours of service are needed, they must be provided by someone living outside the home. Exceptions may be authorized when needed for members who receive services through the Homeward Bound Waiver.

(h) When the member is out of the home for school, work, adult day services or other non-HTS supported activities, the total number of hours of HTS and hours away from the home cannot exceed 12 hours per day unless an exception is granted in accordance with subsection c of this policy.

(i) In accordance with OAC 340:100-3-33.1, services must be provided in the most cost effective manner. When the need for HTS services is expected to continue to exceed 9 hours daily, cost effective community residential services must be considered and requested in accordance with OAC 317:40-1-2. For adults, continuation of non-residential services in excess of 9 hours per day for more than one plan of care year will not be authorized except:

(1) when needed for members who receive services through the Homeward Bound Waiver;

(2) when determined by the division administrator or designee to be the most cost effective option; or

(3) as a transition period of 120 days or less to allow for identification of and transition to a cost effective residential option. Members who do not wish to receive residential services will be assisted to identify options that meet their needs within an average of 9 hours daily.

*[OAR Docket #13-832; filed 5-21-13]*

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## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 45. INSURE OKLAHOMA

*[OAR Docket #13-853]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
317:45-1-2 *[AMENDED]*
Subchapter 11. Insure Oklahoma IP
Part 3. Insure Oklahoma IP Member Health Care Benefits
317:45-11-10 *[AMENDED]*
**(Reference APA WF # 12-24)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Oklahoma Telemedicine Act of 1997; 42 CFR 410.78
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
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N/A
**ANALYSIS:**
OHCA rules are revised to align policy with federal requirements; additionally rules are revised to align adult outpatient behavioral health services with children outpatient behavioral health services in the Individual Plan.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 1. GENERAL PROVISIONS

**317:45-1-2. Program limitations**

(a) The Insure Oklahoma program is contingent upon federal waiver approval and sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, Okla. Stat. '68-302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the

estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma program continues to operate within its fiscal capacity.

(A) Insure Oklahoma may limit eligibility based on:

(i) the federally-approved Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver;

(ii) Tobacco Tax collections; and

(iii) the State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma program are placed on a waiting list. Applications, with the exception of college students, are identified by region and Insure Oklahoma program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate during the employer's current eligibility period.

(vi) For approved employers, if the employer has an employee who has a qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the qualifying event.

(b) College student eligibility and participation in the Insure Oklahoma program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

## SUBCHAPTER 11. INSURE OKLAHOMA IP

## PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

### 317:45-11-10. Insure Oklahoma IP adult benefits

(a) All IP adult benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in 317:45-11-11.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Dependent children coverage is found at 317:45-11-12. Children are not held to the maximum lifetime benefit. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.

(6) Inpatient Hospital Benefits. Covered in accordance with 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.

(8) Office Visits/Specialist Visits. Covered in accordance with 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.

(10) Maternity (Obstetric). Covered in accordance with 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with 317:30-5-20; $0 co-pay.

(12) Mammogram (Radiological or Digital). Covered in accordance with 317:30-5-901; $0 co-pay.

(13) Immunizations. Covered in accordance with 317:30-5-2.

(14) Assistant Surgeon. Covered in accordance with 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.

(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with 317:30-5-95.1; $50 co-pay per admission.

(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). <u>Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.</u>

(A) Agency services. Covered in accordance with 317:30-5-241 and 317:30-5-596; $10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:

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

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under 59 Okla. Stat. § 1353(4) and (5), 59 § 1903(C) and (D), 59 § 1925.3(B) and (C), and 59 § 1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,

(II) Social Work (clinical specialty only),

(III) Professional Counselor,

(IV) Marriage and Family Therapist,

(V) Behavioral Practitioner, or

(VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month per member and 8 testing units per year per member; $10 co-pay per visit.

(19) Durable Medical Equipment and Supplies. Covered in accordance with 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.

(20) Diabetic Supplies. Covered in accordance with 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.

(21) Oxygen. Covered in accordance with 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.

(22) Pharmacy. Covered in accordance with 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with 317:30-5-72.1; $5/$10 co-pay per product.

(24) Nutrition Services. Covered in accordance with 317:30-5-1076; $10 co-pay per visit.
(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with 317:30-5-211.13; $25 co-pay per prosthesis.
(26) Surgery. Covered in accordance with 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.
(27) Home Dialysis. Covered in accordance with 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.
(28) Parenteral Therapy. Covered in accordance with 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.
(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with 317:30-3-57; $0 co-pay.
(30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with 317:30-5-211.15 and 317:30-5-42.16(b)(3).
(31) Fundus photography.
(32) Perinatal dental care for pregnant women. Covered in accordance with 317:30-5-696; $0 co-pay.

*[OAR Docket #13-853; filed 5-21-13]*

## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

*[OAR Docket #13-850]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. Medically Fragile Waiver Services
317:50-1-3. [AMENDED]
317:50-1-6. [AMENDED]
317:50-1-14. [AMENDED]
**(Reference APA WF # 12-30)**
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The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act
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N/A
**ANALYSIS:**
Rules are revised to add Institutional Transition Services and Self-Directed Goods and Services to the Medically Fragile Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

**317:50-1-3. Medically Fragile Program overview**

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution; room and board licensed residential care facility, or licensed assisted living facility. The number of members who may receive Medically Fragile Waiver services is limited.

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be 19 years of age or older;

(B) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

(2) In addition, the individual must meet the following criteria:

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized.

(c) Services provided through the Medically Fragile Waiver are:

(1) case management;

(2) institutional transition services;

(~~2~~3) respite;

~~(3) adult day health care;~~

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy, occupational therapy, respiratory therapy, speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) ~~personal care (state plan),~~ Medically Fragile Waiver personal care;

(13) Personal Emergency Response System (PERS);

(14) ~~Self-Direction; and~~Self Directed personal care, respite and advanced supportive/restorative assistance;

(15) Self Directed Goods and Services (SD-GS); and

(~~15~~16) SoonerCare medical services within the scope of the State Plan.

(d) A service eligibility determination is made using the following criteria:

(1) an open Medically Fragile Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age 19 or older with a physical disability and may also have an intellectual disability or a cognitive impairment.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.

(g) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of their right to appeal the decision.

**317:50-1-6. Determining financial eligibility for the Medically Fragile Waiver program**

Financial eligibility for Medically Fragile Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the Medically Fragile Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Medically Fragile Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income

and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Medically Fragile Waiver Program services is as follows:

(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 form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum 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.

(2) **Individual with a spouse who receives HCBW 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 HCBW 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 HCBW program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW 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 Medically Fragile Waiver 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.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBW 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 the Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum 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.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program.** When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW 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 receiving Medically Fragile Waiver 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 Medically Fragile Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~OAC 317:35-5-41.6(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 Medically Fragile Waiver 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 Medically Fragile Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Medically Fragile program services, OKDHS Form 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 Medically Fragile Waiver program (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 form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, 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 SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of 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 SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Medically Fragile Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Medically Fragile Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, 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 Medically Fragile Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance 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 Medically Fragile Waiver 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) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum 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.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an SNF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(K) When ~~assests~~assets are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving Medically Fragile program services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant

to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty 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.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant 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.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

**317:50-1-14. Description of services**

Services included in the Medically Fragile Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or skilled nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-1-15(1)(A)that only a Medically Fragile case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are Services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Transition Case Management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(~~2~~3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(~~3~~4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

(~~4~~5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

(~~5~~6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(~~6~~7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by

licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(~~7~~8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(~~8~~9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~9~~10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(~~10~~11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~11~~12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~12~~13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. Medically Fragile Waiver Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(~~13~~14) **Medically Fragile Waiver Personal Care.**

(A) Medically Fragile Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Medically Fragile Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

(~~14~~15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an Medically Fragile Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved plan of care.

(~~15~~16) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(~~16~~17) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services approved area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to

make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PSA and APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Respite or Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Respite or Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(I) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the

amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(18) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

*[OAR Docket #13-850; filed 5-21-13]*

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## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

*[OAR Docket #13-840]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. My Life, My Choice
317:50-3-3. [AMENDED]
317:50-3-6. [AMENDED]
317:50-3-14. [AMENDED]
**(Reference APA WF # 12-31)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act
**DATES:**
**Comment period:**
February 1, 2013, through March 3, 2013
**Public hearing:**
March 4, 2013
**Adoption:**
March 14, 2013
**Submitted to Governor:**
March 14, 2013
**Submitted to House:**
March 14, 2013
**Submitted to Senate:**
March 14, 2013
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April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
**Final adoption:**
May 14, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Rules are revised to add Institutional Transition Services, Assisted Living and Self-Directed Goods and Services to the My Life; My Choice Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 3. MY LIFE, MY CHOICE

**317:50-3-3. My Life, My Choice program overview**

(a) The My Life, My Choice program is a Medicaid Home and Community Based Waiver used to finance ~~noninstitutional~~non-institutional long-term care services for a targeted group of physically disabled adults. My Life, My Choice services are outside the scope of state plan Medicaid services. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.

(1) To be considered for My Life, My Choice services, individuals must meet the following criteria:

(A) be 20 to 64 years of age;

(B) be physically disabled; and

(C) have transitioned to a home and community based setting through the Living Choice Program;

(2) In addition, the individual must meet the following minimum UCAT criteria:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or

(II) MSQ score is at the high end of moderate risk range; or

(III) IADLs score is in the high risk range; or

(IV) Nutrition score is in the high risk range; or

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Individual Support is moderate risk; or

(ii) Environment is high risk; or

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless

of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-3-3(a)(2)(A)criteria if untreated; and

(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of My Life, My Choice Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

(4) Meet service eligibility criteria [see OAC 317:50-3-3(c)].

(5) Meet program eligibility criteria [see OAC 317:50-3-3(d)].

(b) Services provided through the My Life, My Choice Waiver are:

(1) case management;

(2) institutional transition services;

(~~2~~3) respite;

(~~3~~4) adult day health care;

(~~4~~5) environmental modifications;

(~~5~~6) specialized medical equipment and supplies;

(~~6~~7) physical therapy;

(~~7~~8) occupational therapy;

(~~8~~9) respiratory therapy;

(~~9~~10) speech therapy;

(~~10~~11) assistive technology;

(~~11~~12) audiology treatment and evaluation;

(~~12~~13) dental services and treatment up to $1,000 annually;

(~~13~~14) family counseling;

(~~14~~15) family training;

(~~15~~16) independent living skills training;

(~~16~~17) nutrition services;

(~~17~~18) psychiatry;

(~~18~~19) psychological services;

(~~19~~20) vision services;

(~~20~~21) pharmacological evaluations;

(~~21~~22) agency companion;

(~~22~~23) advanced supportive/restorative assistance;

(~~23~~24) skilled nursing and private duty nursing;

(~~24~~25) home delivered meals;

(~~25~~26) hospice care;

(~~26~~27) medically necessary prescription drugs within the limits of the waiver;

(~~27~~28) ~~personal care (state plan), or~~ My Life, My Choice personal care;

(~~28~~29) Personal Emergency Response System (PERS);

(~~29~~30) ~~Self-directed services~~Self Directed personal care, respite and advanced supportive/restorative assistance;

(31) Self Directed Goods and Services (SD-GS);

(32) Assisted Living; and

(~~30~~33) all other SoonerCare medical services within the scope of the State Plan, including SoonerRide non-emergency transportation.

(c) A service eligibility determination is made using the following criteria:

(1) an open My Life, My Choice Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all My Life, My Choice Waiver slots are filled, the individual cannot be certified as eligible for My Life, My Choice Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. My Life, My Choice Waiver slots and corresponding waiting lists, if necessary, are maintained.

(2) the individual is in the My Life, My Choice Waiver targeted service group. The target group is an individual who is age 20 to 64 with a physical disability.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(d) The My Life, My Choice Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through My Life, My Choice Waiver program services, SoonerCare

State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of My Life, My Choice Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require My Life, My Choice Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(e) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the My Life, My Choice Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.

(f) Individuals determined ineligible for My Life, My Choice Waiver program services are notified in writing of the determination and of their right to appeal the decision.

**317:50-3-6. Determining financial eligibility for the My Life, My Choice Waiver program**

Financial eligibility for My Life, My Choice Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the My Life, My Choice Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the My Life, My Choice Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in My Life, My Choice Waiver Program services is as follows:

(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 form 08AX001E, Schedule VIII. B. 1., to be eligible for My Life, My Choice Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for My Life, My Choice Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum 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 HCBW 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 HCBW 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 HCBW program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW 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 My Life, My Choice Waiver 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.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for My Life, My Choice Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBW 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 the My Life, My Choice Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum 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.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program.** When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW 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 My Life, My Choice Waiver 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 My Life, My Choice Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~OAC 35-5-41.6(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 My Life, My Choice Waiver 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 My Life, My Choice Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving My Life, My Choice program services, OKDHS Form 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 My Life, My Choice Waiver program (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 form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, 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 SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of 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 SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving My Life, My Choice Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving My Life, My Choice Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, 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 My Life, My Choice Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance 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 My Life, My Choice Waiver 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) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum 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.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an NF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of

transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of My Life, My Choice Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for My Life, My Choice Waiver program services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving My Life, My Choice program services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the

community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty 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.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant 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.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of My Life, My Choice Waiver program services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for My Life, My Choice Waiver program services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

**317:50-3-14. Description of services**

Services included in the My Life, My Choice Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of

care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet My Life, My Choice Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-3-14(1)(A)that only a My Life, My Choice case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are Services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Transition Case Management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(~~2~~3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(~~3~~4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

(~~4~~5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

(~~5~~6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(~~6~~7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services include skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the My Life, My Choice Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's

chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(~~7~~8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(~~8~~9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~9~~10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(~~10~~11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to

reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~11~~12) **Respiratory Therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~12~~13) **Hospice services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. My Life, My Choice Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for My Life, My Choice Facility Based Extended Respite. Hospice provided as part of Facility Based Extended respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive My Life, My Choice Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(~~13~~14) **My Life, My Choice Waiver Personal Care.**

(A) My Life, My Choice Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living,

such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) My Life, My Choice Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) My Life, My Choice Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

(15) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to the member who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security.

(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordination of transportation to and from medical appointments.

(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member's service plan.

(D) Payment is not made for 24 hour skilled care.

(~~14~~16) **Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member. ~~Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.~~

(~~15~~17) **Assistive Technology.** Assistive technology enables the member to maintain or increase functional capabilities. Assistive technology devices are in addition to equipment and supplies readily available through traditional State Plan services and exclude items that are not of direct medical or remedial benefit to the member. Assistive technology includes the purchase, rental, customization, maintenance and repair of such devices.

(~~16~~18) **Audiology Treatment and Evaluation.** Services include evaluation, treatment and consultation related to auditory functioning and are intended to maximize the member's hearing abilities.

(~~17~~19) **Agency Companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(~~18~~20) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed $1,000 per plan year of care. These services may include:

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(~~19~~21) **Family Training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(~~20~~22) **Family Counseling.** Family counseling helps to develop and maintain healthy, stable relationships among all family members in order to support meeting the needs of the member. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home. Services are intended to maximize the member/family's emotional/social adjustment and well-being. All family counseling needs are documented in the member's plan of care. Individual counseling cannot exceed 400, 15-minute units per plan of care year. Group counseling cannot exceed 225, 30-minute units per plan of care year. Case Managers assist the member to identity other alternatives to meet identified needs above the limit.

(~~21~~23) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(~~22~~24) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(~~23~~25) **Independent Living Skills training.** Independent living skills training is a service to support the individual's self-care, daily living, adaptive skills and leisure skills needed to reside successfully in the community. Services are provided in community based settings in a manner that contributes to the individual's independence, self-sufficiency, community inclusion and well-being. This service is intended to train members with significant cognitive problems living skills such as selecting clothing, dressing, and personal shopping.

(~~24~~26) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For a My Life, My Choice Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the My Life, My Choice approved plan of care.

(~~25~~27) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(~~26~~28) **Psychiatry.** Psychiatry provides outpatient psychiatric services provided by a licensed psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in recognition of psychiatric illness and adverse reactions to medications.

(~~27~~29) **Psychological services.** Psychological services include evaluation, psychotherapy, consultation and behavioral treatment. Services are provided in any community setting as specified in the member's service plan. Services are intended to maximize the member's psychological and behavioral well-being. Services are provided in both individual and group (8 person maximum) formats. The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.

(~~28~~30) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

(~~29~~31) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRice NET services is located at 317:30-5-326.

(~~30~~32) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services ~~approved~~ area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PSA and APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Respite or Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Respite Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(I) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the

service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(33) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

*[OAR Docket #13-840; filed 5-21-13]*

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## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
## CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

*[OAR Docket #13-849]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Sooner Seniors
317:50-5-3. [AMENDED]
317:50-5-6. [AMENDED]
317:50-5-14. [AMENDED]
**(Reference APA WF # 12-32)**
**AUTHORITY:**
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act
**DATES:**
**Comment period:**
February 1, 2013, through March 3, 2013
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March 4, 2013
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March 14, 2013
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March 14, 2013
**Submitted to House:**
March 14, 2013
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April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 14, 2013
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May 14, 2013
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
Rules are revised to add Institutional Transition Services, Assisted Living and Self-Directed Goods and Services to the Sooner Seniors Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes.
**CONTACT PERSON:**
Tywanda Cox at 522-7153

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. SOONER SENIORS

**317:50-5-3. Sooner Seniors program overview**

(a) The Sooner Seniors program is a Medicaid Home and Community Based Waiver used to finance ~~noninstitutional~~non-institutional long-term care services for a targeted group of elderly adults. Sooner Seniors services are outside the scope of state plan Medicaid services. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.

(1) To be considered for Sooner Seniors services, individuals must meet the following criteria:

(A) be age 65 years or older;

(B) have a clinically documented, progressive degenerative disease process that responds to treatment and requires Sooner Seniors Waiver services to maintain the treatment regimen to prevent health deterioration and remain in a home and community based setting;

(C) have transitioned to a home and community based setting through the Living Choice Program;

(2) In addition, the individual must meet the following minimum UCAT criteria:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or

(II) MSQ score is at the high end of moderate risk range; or

(III) IADLs score is in the high risk range; or

(IV) Nutrition score is in the high risk range; or

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Individual Support is moderate risk; or

(ii) Environment is high risk; or

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-5-3(a)(2)(A)criteria if untreated; and

(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of Sooner Seniors Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

(4) Meet service eligibility criteria [see OAC 317:50-5-3(c)].

(5) Meet program eligibility criteria [see OAC 317:50-5-3(d)].

(b) Services provided through the Sooner Seniors Waiver are:

(1) case management;

(2) institutional transition services;

(~~2~~3) respite;

(~~3~~4) adult day health care;

(~~4~~5) environmental modifications;

(~~5~~6) specialized medical equipment and supplies;

(~~6~~7) physical therapy;

(~~7~~8) occupational therapy;

(~~8~~9) respiratory therapy;

(~~9~~10) speech therapy;

(~~10~~11) dental services and treatment up to $1,000 annually;

(~~11~~12) family training services;

(~~12~~13) nutritional education services;

(~~13~~14) vision services;

(~~14~~15) pharmacological evaluations;

(~~15~~16) agency companion;

(~~16~~17) advanced supportive/restorative assistance;

(~~17~~18) skilled nursing and private duty nursing;

(~~18~~19) home delivered meals;

(~~19~~20) hospice care;

(~~20~~21) medically necessary prescription drugs within the limits of the waiver;

(~~21~~22) ~~personal care (state plan),~~ Sooner Seniors personal care;

(~~22~~23) Personal Emergency Response System (PERS);

(~~23~~24) ~~Self-directed services~~Self Directed personal care, respite and advanced supportive/restorative assistance;

(24) Self Directed Goods and Services (SD-GS);

(25) Assisted Living; and

(~~24~~26) All other SoonerCare medical services within the scope of the State Plan, including SoonerRide non-emergency transportation.

(c) A service eligibility determination is made using the following criteria:

(1) an open Sooner Seniors Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Sooner Seniors Waiver slots are filled, the individual cannot be certified as eligible for Sooner Seniors Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. Sooner Seniors Waiver slots and corresponding waiting lists, if necessary, are maintained.

(2) the individual is in the Sooner Seniors Waiver targeted service group. The target group is an individual who is age 65 or older with a chronic medical condition.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(d) The Sooner Seniors Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through

Sooner Seniors Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Sooner Seniors Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require Sooner Seniors Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(e) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Sooner Seniors Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.

(f) Individuals determined ineligible for Sooner Seniors Waiver program services are notified in writing of the determination and of their right to appeal the decision.

**317:50-5-6. Determining financial eligibility for the Sooner Seniors Waiver program**

Financial eligibility for Sooner Seniors Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the Sooner Seniors Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Sooner Seniors Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Sooner Seniors Waiver Program services is as follows:

(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 form 08AX001E, Schedule VIII. B. 1., to be eligible for Sooner Seniors Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~ OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for Sooner Seniors Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum 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 HCBW 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 HCBW 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 HCBW program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW 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 Sooner Seniors Waiver 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.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Sooner Seniors Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~ OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBW 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 the Sooner Seniors Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum 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.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program.** When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW 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 Sooner Seniors Waiver 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 Sooner Seniors Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC 317:35-5-41.6(a)(6)(B)~~OAC 317:35-5-41.6(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 Sooner Seniors Waiver 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 Sooner Seniors Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Sooner Seniors program services, OKDHS Form 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 Sooner Seniors Waiver program (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 form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, 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 SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of 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 SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Sooner Seniors Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Sooner Seniors Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, 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 Sooner Seniors Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance 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 Sooner Seniors Waiver 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) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum 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.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an NF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of

transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Sooner Seniors Waiver program services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving Sooner Seniors program services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the

community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty 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.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant 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.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Sooner Seniors Waiver program services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

**317:50-5-14. Description of services**

Services included in the Sooner Seniors Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of

care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Sooner Seniors Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-5-14(1)(A)that only a Sooner Seniors case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(~~2~~3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(~~3~~4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

(~~4~~5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

(~~5~~6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(~~6~~7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services include skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Sooner Seniors Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's

chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(~~7~~8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(~~8~~9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~9~~10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(~~10~~11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to

reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~11~~12) **Respiratory therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involved s use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(~~12~~13) **Hospice services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. Sooner Seniors Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Sooner Seniors Facility Based Extended Respite. Hospice provided as part of Facility Based Extended respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Sooner Seniors Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(~~13~~14) **Sooner Seniors Waiver Personal Care.**

(A) Sooner Seniors Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or

minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Sooner Seniors Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Sooner Seniors Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

(15) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to the member who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security.

(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordination of transportation to and from medical appointments.

(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member's service plan.

(D) Payment is not made for 24 hour skilled care.

(~~14~~16) **Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member. ~~Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.~~

(~~15~~17) **Agency companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(~~16~~18) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed $1,000 per plan year of care. These services may include:

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(~~17~~19) **Family training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(~~18~~20) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(~~19~~21) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(~~20~~22) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For a Sooner Seniors Program member to be eligible to receive PERS

service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Sooner Seniors approved plan of care.

(~~21~~23) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(~~22~~24) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

(~~23~~25) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.

(~~24~~26) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services ~~approved~~ area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant.

The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PSA and APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training

and supervising the member's Respite or Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Respite or Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(I) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(27) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

*[OAR Docket #13-849; filed 5-21-13]*

## TITLE 325. OKLAHOMA HORSE RACING COMMISSION
## CHAPTER 15. LICENSING

*[OAR Docket #13-905]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
325:15-1-2. Definitions [AMENDED]
Subchapter 5. Occupation Licensing
325:15-5-3. Employment of unlicensed person [AMENDED]
325:15-5-20. Program trainer prohibited [AMENDED]
**AUTHORITY:**
75 Oklahoma Statutes §§ 302, 305, and 307; Title 3A O.S., § 204(A); Oklahoma Horse Racing Commission
**DATES:**
**Comment Period:**
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Failure of the Legislature to disapprove the rules resulted in approval on May 23, 2013
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May 23, 2013
**Effective:**
June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
Not Applicable
**INCORPORATED BY REFERENCE:**
Not Applicable
**ANALYSIS:**
Commission Executive Director Constantin Rieger and Ms. Mary Ann Roberts, OHRC Staff Attorney, propose amending Rule 325:15-5-3 to change the term 'valid license' to 'current license' with an explanation that the current license allows the person's participation in the capacity for which the person is employed. Mr. Rieger proposes to amend Rule 325:15-1-2 to add a Program Trainer definition and then amend 325:15-5-20 not to allow any Licensee to act as a Program Trainer or use the services of a Program Trainer.
**CONTACT PERSON:**
Bonnie Morris, Agency Rulemaking Liaison, Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107, (405) 943-6472

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE AMENDMENTS ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

**325:15-1-2. Definitions**

In addition to the definitions provided in Section 200.1 of Title 3A, of the Oklahoma Statutes, the following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

**"Act"** means the Oklahoma Horse Racing Act [3A:200 et seq.].

**"Authorized agent"** means a person licensed by the Commission and appointed by a written notarized affidavit by the Owner in whose behalf the Agent will act. Said affidavit must be on file with the Commission.

**"Commissioner"** means a member of the Oklahoma Horse Racing Commission.

**"Controlling owner"** means a person or family who owns or votes fifty percent (50%) or more of the voting shares of a corporation, partnership, syndicate, or other association or entity or who is the Managing, General, or Limited Partner in a partnership which has been issued a currently valid organization license.

**"Day"** means a 24-hour period ending at midnight.

**"Dark day"** means a day during a live race meeting when no pari-mutuel wagering is conducted.

**"Entry"** means:

(A) A horse eligible for and entered in a race.

(B) Two (2) or more horses entered in the same race which have common ties of ownership, lease, or training.

**"Horse"** means:

(A) any equine including and designated as mare, filly, stallion, colt, ridgeling, or gelding registered for racing;

(B) an entire equine male five years of age and older.

**"Horse racing facility - major pari-mutuel"** means a facility having those physical and locational characteristics in accord with the Oklahoma Horse Racing Act and which will qualify it for the Breeders', Cup Series or other graded stakes races as granted by The North American Graded Stakes Committee, or both.

**"Jockey"** means a rider licensed to race.

**"Jockey Agent"** means a licensed, authorized representative of a Jockey.

**"Lessee"** means a licensed Owner whose interest in a horse is by virtue of a completed Commission-approved lease form attached to the Registration Certificate and on file with the Commission.

**"Lessor"** means the Owner of a horse that is leased.

**"Occupation license"** means a state requirement for any person acting in any capacity pursuant to provisions of the Act.

**"Organization license"** means a state requirement for any person desiring to conduct a race meeting in Oklahoma within the minimum standards as required by the Act and the rules of the Commission.

**"Owner"** means any person who holds in whole or in part, any right, title or interest in a horse or an organization licensee or any person who is a lessee of a horse and has been duly issued a currently-valid Owner license as a person responsible for such horse.

**"Program Trainer"** is a licensed Trainer who, for the purposes of the official Race program, is identified as the Trainer of a horse and is acting on behalf of another individual that is either licensed or not licensed, cannot be licensed, is prohibited from racing for any reason, or is attempting to assume the appearance of being the trainer of a horse that he/she does not have in his/her care, custody or control, or which is under the control of and/or trained by the licensed or unlicensed individual.

**"Race"** means a contest between horses.

**"Race Day"** means a day during a race meeting when pari-mutuel wagering occurs on live races conducted at that racetrack.

**"Restricted area"** means any area within the enclosure where access is limited to licensees whose occupation requires access. Those areas which are restricted shall include but not be limited to the barn area, paddock, test barn, Stewards', tower, racecourse, mutuel line and money rooms, or any other area designated restricted by the organization licensee or the Commission or both. Signs giving notice of restricted access shall be prominently displayed at all entry points.

**"Rules"** means the rules adopted by the Commission to implement the provisions of the Act.

**"Scratch time"** means the deadline for withdrawal of entries from an overnight race.

**"Shareholder"** means a person who owns some share of ownership, including entitlement to potential profits or losses in a corporation, partnership, syndicate, association or other multiple ownership entity.

**"Stable name"** means a name used other than the actual legal name of an Owner or lessee which is registered with the Commission.

**"Steward"** means a duly appointed Racing Official with powers and duties specified by statutes or rules.

**"Trainer"** means a person qualified and licensed by the Commission as a Trainer.

**"Week"** means a calendar week.

**"Year"** means a calendar year.

## SUBCHAPTER 5. OCCUPATION LICENSING

**325:15-5-3. Employment of Unlicensed Person**

No organization, Owner, Trainer or other licensee acting as an employer within the enclosure at an authorized race meeting shall employ or harbor within the enclosure any person

required to be licensed by the Commission until such organization, Owner, Trainer, or other employer determines that such person required to be licensed has been issued a ~~valid~~current license by the Commission and that license allows their participation in the capacity for which they are employed. No organization shall permit any Owner, Trainer, Jockey, Apprentice Jockey, or Exercise Rider to own, train, or ride a horse on its premises during a recognized race meeting unless such person has obtained the appropriate license(s) from the Commission. The organization or prospective employer may demand for inspection the license of any person participating or attempting to participate at its race meeting, and the organization may demand for inspection the documents relating to any horse within the enclosure.

**325:15-5-20. Program Trainer Prohibited**

~~No licensed Trainer, for the purpose of avoiding his/her responsibilities or insurance requirements as set forth in the rules of this Subchapter, shall place any horse in the care or attendance of any other Trainer.~~No licensee shall act as a Program Trainer, nor shall anyone use the services of a Program Trainer. Anyone found to be acting as a Program Trainer is responsible for all violations occurring from participation of the horse(s) entered or raced by that person.

*[OAR Docket #13-905; filed 5-23-13]*

## TITLE 325. OKLAHOMA HORSE RACING COMMISSION
## CHAPTER 20. RACING OFFICIALS AND RACING PERSONNEL

*[OAR Docket #13-906]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULE:**
325:20-1-22. Duties of the Racing Veterinarian [AMENDED]
**AUTHORITY:**
75 Oklahoma Statutes §§ 302, 305, and 307; Title 3A O.S., § 204(A); Oklahoma Horse Racing Commission
**DATES:**
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June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
**Superseded rule:**
325:20-1-22. Duties of the Racing Veterinarian [AMENDED]
**Gubernatorial approval:**
February 11, 2013
**Register publication:**
30 Ok Reg 395
**Docket number:**
13-324
**INCORPORATED BY REFERENCE:**
Not Applicable
**ANALYSIS:**
The Commission's Ad Hoc Committee on Medications proposes an additional responsibility for the Racing Veterinarian who is an employee of the racetrack: conducting pre-race examinations of entered horses as required by a Horse Racing Commission employee [either a Steward or the Official Veterinarian]. The objective is to reduce the number of breakdowns of horses from racing injuries by not allowing those horses that do not pass the pre-race examination to race.

This rule amendment was first approved through the emergency rulemaking process and became effective February 11, 2013 upon gubernatorial approval. This current action is to make the changes permanent.
**CONTACT PERSON:**
Bonnie Morris, Agency Rulemaking Liaison, Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107, (405) 943-6472

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE AMENDMENTS ARE CONSIDERED FINALLY ADOPTED AS SET OF JUNE 27, 2013:**

**325:20-1-22. Duties of the Racing Veterinarian**

The Racing Veterinarian must be a graduate veterinarian and licensed to practice in the State of Oklahoma. The Racing Veterinarian shall be present in the paddock on the racing course, and at the starting gate during the saddling, the parade, and until the horses are dispatched from the gate for the race; ~~and~~ shall examine any horse when there is a question as to the physical condition of such a horse; and, as the Stewards or the Official Veterinarian require, shall conduct pre-race examinations of entered horses. He or she shall report any horse, which in their opinion is incapable of physically exerting its best effort to win, to the Stewards, who may scratch such horse from the race. The Racing Veterinarian shall examine any horse which appears in physical distress during the race, at the finish of the race; and s/he shall report such horse together with their opinion as to the cause of the distress to the Stewards and to the Official Veterinarian. No Racing Veterinarian shall directly treat or prescribe for any horse scheduled to participate during their term of appointment at any recognized meeting except in an emergency. The Racing Veterinarian has the authority to treat any horse in the event of an emergency, accident or injury; and s/he is authorized to humanely destroy any horse which in their opinion is so seriously injured that it is in the best interests of racing to so act; and every horse owner and Trainer participating in Commission- licensed racing does consent to the humane destruction of such animal. In the case of a horse which has suffered a catastrophic injury, the Racing Veterinarian may obtain a blood sample from the injured horse prior to taking any humane actions necessary. If the trainer is immediately available, he or she may witness the collection process. If the trainer is not immediately available to witness

the collection process, any other Commission-licensed individual shall act as the witness to the collection process.

*[OAR Docket #13-906; filed ??-??-??]*

## TITLE 325. OKLAHOMA HORSE RACING COMMISSION
## CHAPTER 25. ENTRIES AND DECLARATIONS

*[OAR Docket #13-907]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
325:25-1-5. Entries [AMENDED]
325:25-1-32. Coggins test [AMENDED]
**AUTHORITY:**
75 Oklahoma Statutes §§ 302, 305, and 307; Title 3A O.S., § 204(A); Oklahoma Horse Racing Commission
**DATES:**
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**Legislative approval:**
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**Final Adoption:**
May 23, 2013
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June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
Not Applicable
**INCORPORATED BY REFERENCE:**
Not Applicable
**ANALYSIS:**
Commission Executive Director Constantin Rieger proposes amending Rule 325:25-1-5 to clarify when a Trainer may train for another Trainer. The proposed amendment would expand the prohibition that no Trainer who is an Owner or Part Owner of a horse may enter that horse under the name of another Trainer **in the same race** to **any overnight race.** For Rule 325:25-1-32, Dr. Rudy Garrison, Commission Official Veterinarian, recommends the following amendments to broaden the requirement of a negative Coggins Test to all horses that enter an Oklahoma racetrack, including pony horses. He also suggests clarification of the requirement of the negative test for race horses entering a race to be an original Veterinary Service [VS] Form 10-11 attached to the horse's registration papers or an electronic version to be attached to the registration papers and conducted within 12 months of the race in question. A penalty for non-compliance is proposed as disciplinary action.
**CONTACT PERSON:**
Bonnie Morris, Agency Rulemaking Liaison, Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107, (405) 943-6472

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE AMENDMENTS ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013**

### 325:25-1-5. Entries

No horse shall be entered in more than one (1) race on the same day. No person shall enter or attempt to enter a horse in a race unless such entry is a bona fide entry made with the intention that such horse is to compete in the race for which entry is made except, if race conditions permit, for entry back in finals or consolations involving physically disabled or dead qualifiers for purse payment purposes. No Trainer who is an Owner or part Owner of a horse may enter that horse under the name of another Trainer in ~~the same race~~any overnight race if both the trainer and the owner/trainer have an active trainer file in the racing office for that breed of horse at that race meeting.

### 325:25-1-32. Coggins test

No horse shall be allowed ~~to~~on the premises of an Oklahoma racetrack~~race in Oklahoma~~ unless it has had a Coggins test conducted within 12 months and with a negative result. The test record may be a copy of the original Coggins test.~~taken within 12 months of the date of the race in question with a negative result~~. Record of the negative test for a race horse participating in a race shall be the original VS Form 10-11 or an approved electronic version attached to the registration papers of the horse and conducted within 12 months of the race in question. The trainer of the race horse is responsible for insuring that a negative Coggins test result is in the racing secretary's office as required by this rule prior to racing. Failure to comply subjects the Licensee to disciplinary action.

*[OAR Docket #13-907; filed 5-23-13]*

## TITLE 325. OKLAHOMA HORSE RACING COMMISSION
## CHAPTER 40. VETERINARIAN PRACTICES

*[OAR Docket #13-908]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
325:40-1-2. Definitions [AMENDED]
325:40-1-3. Veterinary practices - Treatment restricted [AMENDED]
**AUTHORITY:**
75 Oklahoma Statutes §§ 302, 305, and 307; Title 3A O.S., § 204(A); Oklahoma Horse Racing Commission
**DATES:**
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**SUPERSEDED EMERGENCY ACTIONS:**
Not Applicable
**INCORPORATED BY REFERENCE:**
Not Applicable
**ANALYSIS:**
Dr. Rudy Garrison, Commission Official Veterinarian, recommends amending the two rules to be in compliance with the Oklahoma Veterinary Practice Act that now uses the title of Registered Veterinary Technician rather than Certified Veterinary Technician.
**CONTACT PERSON:**
Bonnie Morris, Agency Rulemaking Liaison, Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107, (405) 943-6472

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE AMENDMENTS ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

**325:40-1-2. Definitions**

In addition to the definitions provided in Section 200.1 of Title 3A, of the Oklahoma Statutes, the following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**Act**" means the Oklahoma Horse Racing Act [3A:200 et seq.].

"**~~Certified~~Registered Veterinary Technician**" means a person who is ~~certified~~ registered~~as an Animal Technician or Veterinarian Technician~~ by the Oklahoma Board of Veterinary Medical Examiners and licensed by the Commission as a ~~Certified~~Registered Veterinary Technician. A licensed ~~Certified~~Registered Veterinary Technician must perform all work on the racetrack enclosure under the direct supervision of a Veterinarian licensed in Oklahoma, except that a ~~Certified~~Registered Veterinary Technician shall not be permitted to administer medication to any entered horse.

"**Commissioner**" means a member of the Oklahoma Horse Racing Commission.

"**Controlled substance**" means any substance included in the five classification schedules of the Oklahoma Uniform Controlled Dangerous Substances Act.

"**Day**" means a 24-hour period ending at midnight.

"**Drug (medication)**" means a substance foreign to the normal physiology of the horse.

"**Foreign substances**" means all substances except those which exist naturally in the untreated horse at normal physiological concentration and shall include but not be limited to all narcotics, stimulants, or depressants.

"**Horse**" means:

(A) any equine including and designated as mare, filly, stallion, colt, ridgeling, or gelding registered for racing;

(B) an entire equine male five years of age and older.

"**Medication**" means a substance other than food intended to affect the structure or any function of the body of a human or a horse.

"**Occupation license**" means a state requirement for any person acting in any capacity pursuant to the provisions of the Act.

"**Official Veterinarian**" means a person qualified and licensed by the Commission as Official Veterinarian.

"**Organization license**" means a state requirement for any person desiring to conduct a race meeting in Oklahoma within the minimum standards as required by the Act and the rules of the Commission.

"**Owner**" means any person who holds in whole or in part, any right, title or interest in a horse or an organization licensee or any person who is a lessee of a horse and has been duly issued a currently-valid Owner license as a person responsible for such horse.

"**Race**" means a contest between horses.

"**Race day**" means a day during a race meeting when pari-mutuel wagering occurs on live races conducted at that racetrack.

"**Racing Veterinarian**" means a person qualified and licensed by the Commission as Racing Veterinarian.

"**Restricted area**" means any area within the enclosure where access is limited to licensees whose occupation requires access. Those areas which are restricted shall include but not be limited to the barn area, paddock, test barn, Stewards' tower, racecourse, mutuel line and money rooms, or any other area designated restricted by the organization licensee or the Commission, or both. Signs giving notice of restricted access shall be prominently displayed at all entry points.

"**Rules**" means the rules adopted by the Commission to implement the provisions of the Act.

"**Steward**" means a duly appointed Racing Official with powers and duties specified by statutes or rules.

"**Trainer**" means a person qualified and licensed by the Commission as a Trainer.

"**Veterinarian**" means a person licensed to practice veterinary medicine by the State of Oklahoma and licensed as a Veterinarian by the Commission.

"**Week**" means a calendar week.

"**Year**" means a calendar year.

**325:40-1-3. Veterinary practices - Treatment restricted**

No person other than an Oklahoma-licensed Veterinarian or ~~Certified~~Registered Veterinary Technician under the direct supervision of a licensed Veterinarian who has obtained a license from the Commission shall administer to any horse within the enclosure any veterinary treatment or any medicine, medication, or other substance recognized as a medication, except for recognized feed supplements or oral tonics or substances approved by the Official Veterinarian. "Administer" shall be defined as anything permitted under the Oklahoma Veterinary Practice Act [59 O.S., § 698.1 et seq.] or allowed

for a ~~Certified~~Registered Veterinary Technician under the Oklahoma Veterinary Practice Act, except a ~~Certified~~Registered Veterinary Technician shall not be permitted to administer medications to any entered horse.

*[OAR Docket #13-908; filed 5-23-13]*

## TITLE 325. OKLAHOMA HORSE RACING COMMISSION
## CHAPTER 80. GAMING LICENSING REQUIREMENTS

*[OAR Docket #13-909]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULE:**
Subchapter 15. Requirements for Independent Testing Laboratory License
325:80-15-1. Application required [AMENDED]
**AUTHORITY:**
75 Oklahoma Statutes §§ 302, 305, and 307; Title 3A O.S., § 204(A); Oklahoma Horse Racing Commission
**DATES:**
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June 27, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
Not Applicable
**INCORPORATED BY REFERENCE:**
Not Applicable
**ANALYSIS:**
Commission Staff recommends that an application deadline date be set for renewal license applications for Independent Testing Laboratories [of gaming devices] for the Commission to receive such license applications by October 1 of the current year to allow earlier fall review time by the Law Enforcement Division. After the review, the Hearing before the Commission could be scheduled for the November meeting of the current year to have the License Order executed at the January meeting of the next year.

In recent years, the Commission set fall deadlines for renewal license applications for such gaming licensees as Manufacturers, Distributors, Manufacturers/ Distributors and Vendors and their respective employees. This earlier application deadline allowed more review time rather than receiving the renewal applications by the end of the calendar day when the licenses for the upcoming calendar year needed to be in place as soon as possible. Likewise, setting a fall deadline for the renewal license applications for Independent Testing Laboratories of gaming devices would allow a more timely review and then hearing before the Commission with the renewal license being in place early in the effective year.
**CONTACT PERSON:**
Bonnie Morris, Agency Rulemaking Liaison, Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107, (405) 943-6472

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE AMENDMENT IS CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

### SUBCHAPTER 15. REQUIREMENTS FOR INDEPENDENT TESTING LABORATORY LICENSE

**325:80-15-1. Application Required**

Testing laboratories that wish to function as a Commission-approved Independent Testing Laboratory must apply to be issued an Independent Testing Laboratory License. The application must be accompanied by the required application fee and an investigation fee in an amount equal to one-half of the license fee. The deadline for renewal license applications is October 1 of the current license year.

(1) In addition to other information required on the application, any applicant must provide the following information for each of the last three years:

(A) address of main office and number of square feet used for testing;

(B) addresses of all satellite offices, if any, and number of square footage;

(C) number of full-time employees;

(D) number of machines tested;

(E) list of states for which the Laboratory has performed tests;

(F) list of countries for which the Laboratory has performed tests;

(G) list of states and countries in which the Laboratory has been licensed or certified.

(2) In addition, the Commission review of consideration of an application for an Independent Testing Laboratory shall include:

(A) For the testing laboratory and its parent corporation, if any, a complete corporate financial disclosure and review; a complete disclosure and review of any criminal proceedings, civil litigation or investigations by a regulatory entity; and an evaluation of its corporate good standing in the jurisdiction(s) where it is incorporated and/or does business.

(B) For its principal shareholders (10% or greater) and its officers and directors, a complete individual financial disclosure and review; a complete disclosure and review of any criminal proceedings, civil litigation or investigations by a regulatory entity; and a finding of suitability.

(C) The testing laboratory will demonstrate its relevant technical skill and capability by providing evidence of suitable testing previously conducted for state or tribal regulatory authorities. The Commission's Law Enforcement Division may conduct an on-site review of the testing laboratory's facilities as

part of its evaluation and will be satisfied that the testing laboratory is qualified and competent to perform the testing required before making any recommendation for approval to the Commission. The frequency of the on-site review will be recommended by the Commission Law Enforcement Division's Director to the Commission Executive Director.

(D) The testing laboratory must have in-house staff personnel in the following categories:

(i) Mathematicians

(ii) Mechanical, electrical and software engineering staff

(iii) Compliance engineering staff

(iv) Accounting system and communication protocol engineering specialists

(v) High-level engineering staff for new and current technology

(vi) Quality assurance staff

(E) The testing laboratory must have the ability to provide twenty-four hour, seven-day a week support for the Commission, including in-house personnel coverage.

(F) The testing laboratory must provide training and support staff for on-site field inspections to assist and/or train Gaming Agents on the security, compliance and accounting/auditing practices that should be used, with expenses paid by the testing laboratory.

(G) The testing laboratory must provide a quality assurance staff that verifies each test result.

(H) The testing laboratory must conduct an annual due diligence investigation on each employee of the testing laboratory and maintain such due diligence files on each employee.

(I) The testing laboratory must have physical building security in terms of surveillance systems and alarms to protect confidential information.

(J) The testing laboratory must demonstrate that it possesses multiple units of the approved signature device(s); that it provides signatures of the approved software with each certification which will assist in the conduct of field audits of the equipment; and that the Laboratory has the ability to provide the specifications on the various software verification methods (i.e., KOBETRON, DataMan and other types of algorithms that allow checking of gaming equipment) to assist the Commission in determining which verification tools will be acceptable.

(K) The testing laboratory must have adequate equipment to support the submissions for testing and also, additional units available for on-site inspections when laboratory presence is requested; must provide the requested signatures by taking those signatures at the Laboratory prior to storage of the storage media independent of the supplier; and a testing laboratory shall not rely on supplier-generated signatures.

(L) During the detailed communication protocol tests that are performed on the device side and the system side, the testing laboratory must use testing tools and testing techniques that are developed in compliance with the protocol used. The testing laboratory must have the ability to develop such tools independently without having to reply on the Manufacturer for the equipment.

(M) The testing laboratory must demonstrate that the testing it performs includes complete detailed tests to examine all external and internal functions, such as examinations of memory and communication protocol with all devices, of the gaming equipment being tested.

(N) The testing laboratory must have a national reputation for honesty, independence, competence and timeliness.

*[OAR Docket #13-909; filed 5-23-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 1. FUNCTION AND STRUCTURE OF THE ~~DEPARTMENT~~OKLAHOMA DEPARTMENT OF HUMAN SERVICES

*[OAR Docket #13-885]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
340:1-1-1 through 340:1-1-2 [AMENDED]
340:1-1-3 [REVOKED]
340:1-1-4 [AMENDED]
340:1-1-17 [AMENDED]
340:1-1-18 [REVOKED]
340:1-1-19 [AMENDED]
**(Reference WF 12-22)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes (56 O.S. § 162); 25 O.S. §§ 301 through 314; and Article XXV, Sections 2 and 4 of the Oklahoma Constitution repealed November 6, 2012.
**DATES:**
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July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a

**ANALYSIS:**

The proposed revisions to Subchapter 1 of Chapter 1 amend rules to comply with Constitution and Statute changes.

**CONTACT PERSON:**

Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

### 340:1-1-1. Purpose

This Chapter describes the Oklahoma Department of Human Services (OKDHS) organizational structure and function ~~of the Oklahoma Department of Human Services (OKDHS). It includes the legal basis and outlines other rules governing overall operation of OKDHS~~and includes the legal basis and other rules governing OKDHS operations.

### 340:1-1-2. Legal basis

~~The Oklahoma Department of Public Welfare was created by an amendment to the Constitution of the State of Oklahoma adopted by a vote of the people on July 7, 1936. Article XXV of the Constitution created the Oklahoma Public Welfare Commission, later designated by statute as the Commission for Human Services and provided for the selection of a Director of Public Welfare, now identified as the Director of Human Services.~~The position of Director of Human Services is authorized by Section 162 of Title 56 of the Oklahoma Statutes. The responsibilities of the Oklahoma Department of Human Services, and the Director's authority to see those responsibilities are carried out, is found in the Oklahoma Statutes.

### 340:1-1-3. The Commission for Human Services [REVOKED]

~~(a) Article XXV of the Constitution of the State of Oklahoma places the Department of Human Services under the control of the Commission for Human Services. The Commission is composed of nine members appointed by the Governor and selected on the basis of recognized interest in public welfare. Terms of office of the Commission members are for nine years each, with the term of one commission member expiring each year. One member of the Commission is designated by the Governor as chairman. Commission members receive no compensation for their services but are reimbursed for necessary travel and other expenses actually incurred in the performance of their official duties.~~

~~(b) The Commission selects a Director of Human Services, who is not a member of the Commission, to serve as the executive and administrative officer of the Department. The Commission is responsible for formulating Department policies and adopting rules and regulations for the effective administration of the duties of the Department. The Commission has the authority to accept monies, gifts, and bequests of real and personal property, which become available for operation of programs under the jurisdiction of the Department. The meetings of the Commission are subject to the Open Meetings Act. [25 O.S. § 301-314]~~

### 340:1-1-4. Director of Human Services

(a) The Director of Human Services (Director) serves, at the pleasure of the ~~Commission for Human Services (Commission)~~Governor with Senate confirmation, as the Oklahoma Department of Human Services (OKDHS) chief executive and administrative officer ~~of the Oklahoma Department of Human Services (OKDHS)~~. ~~Under the oversight of the Commission, the~~The Director is charged with the responsibility for ~~day-to-day~~the daily direction of the activities necessary for OKDHS to attain its mission.

(b) The Director's duties ~~include:~~are described in Section 162 of Title 56 of the Oklahoma Statutes.

~~(1) ensuring that OKDHS is working toward the mission and the goals established by the Commission and the Director through aggressive implementation of the planning and budgeting system;~~

~~(2) serving as staff to the Commission by providing necessary input for decision making and ensuring that actions approved by the Commission are carried out;~~

~~(3) developing and maintaining cooperative relationships with federal and state lawmakers and other officials to ensure the fulfillment of the OKDHS mission;~~

~~(4) maximizing all available resources for the delivery of services to the clients OKDHS is charged to serve;~~

~~(5) serving as the chief spokesperson for OKDHS and advocate for OKDHS clients it serves;~~

~~(6) ensuring the coordination of services with other state agencies;~~

~~(7) selecting staff capable of carrying out the OKDHS mission for the areas immediately under the Director's supervision by:~~

~~(A) establishing job descriptions and specifications for each of those positions;~~

~~(B) delegating authority to complete duties assigned; and~~

~~(C) overseeing the accomplishment of assigned responsibilities; and~~

~~(8) directly supervising the:~~

~~(A) administrator, Office for Civil Rights;~~

~~(B) advocate general, Office of Client Advocacy;~~

~~(C) chief administrative officer, Administrative Services;~~

~~(D) chief coordinating officer, Vertically Integrated Services Divisions;~~

~~(E) chief financial officer, Finance Division;~~

~~(F) chief information officer, Data Services Division;~~

~~(G) chief operating officer, Human Services Centers;~~

~~(H) general counsel, Legal Division; and~~

~~(I) inspector general, Office of Inspector General.~~

**340:1-1-17. Organizational structure**

(a) ~~**Commission for Human Services (Commission).** The Oklahoma Department of Human Services (OKDHS) is governed by a nine-member Commission. Each Commissioner is appointed by the Governor of Oklahoma to serve a nine-year term. The Commission selects a Director of Human Services (Director) who is responsible for oversight of OKDHS.~~**Citizen advisory panels.** Section 162.1b of Title 56 of the Oklahoma Statutes creates four citizen advisory panels (Panels) each with five members for issues regarding children and families, aging, disabilities, and administration. The Panels' purpose is to evaluate OKDHS core program and administrative areas and develop recommendations to improve them. The Panels provide advice, information, findings, and analysis to the Director of Human Services (Director) regarding Oklahoma Department of Human Services (OKDHS) policies, practices, and impact on outcomes. At the call of the Director, all Panels meet together at least one time per year in a Joint Citizens Advisory Panel.

(b) **Organizational chart.** OKDHS is organized as the Director ~~and Commission deemdesirable~~ deems appropriate to ~~carry out~~achieve the OKDHS mission. ~~Organizational charts are available upon request to~~ OKDHS Administrative Services provides organizational charts upon request.

~~(c) **Offices and divisions within the OKDHS.** The functions of the offices and divisions within OKDHS are outlined in this subsection.~~

~~(1) **Administrative Services.** The chief administrative officer serves as coordinator of the administrative divisions within OKDHS and provides oversight of divisions that report directly to the Director. Administrative divisions under Administrative Services are:~~

~~(A) Human Resources Management Division (HRMD);~~

~~(B) Support Services Division (SSD);~~

~~(C) Office of Communications;~~

~~(D) Office of Volunteerism;~~

~~(E) Office of Information and Referral;~~

~~(F) Office of Intergovernmental Relations and Policy (OIRP); and~~

~~(G) the divisions responsible for the functions that report directly to the Director, which are:~~

~~(i) Office of Client Advocacy;~~

~~(ii) Office of Inspector General; and~~

~~(iii) Office for Civil Rights.~~

~~(2) **Legal Division.** The general counsel serves as the coordinator of the Legal Division and as chief legal counsel to the Commission and the Director.~~

~~(3) **Human Services Centers.** The chief operating officer serves as coordinator of services delivered through offices in each county. Divisions within the Human Services Centers are:~~

~~(A) Family Support Services Division (FSSD);~~

~~(B) Children and Family Services Division (CFSD); and~~

~~(C) Field Operations Division (FOD).~~

~~(4) **Information Services Divisions.** The chief information officer serves as coordinator of OKDHS information technology. Divisions and offices within information services are:~~

~~(A) Data Services Division (DSD);~~

~~(B) Office of Planning, Research, and Statistics (OPRS);~~

~~(C) Enterprise Project Management Office; and~~

~~(D) Information Security Office.~~

~~(5) **Financial services.** The chief financial officer serves as coordinator of the Finance Division and is responsible for the coordination of OKDHS financial services.~~

~~(6) **Vertically Integrated Services Divisions.** The chief coordinating officer serves as coordinator of program divisions, which have vertically integrated administrations. For example, field staff and program design staff are under the same administrative structure. Divisions included in the vertically integrated services are:~~

~~(A) Aging Services Division (ASD);~~

~~(B) Oklahoma Child Care Services (OCCS);~~

~~(C) Oklahoma Child Support Services (OCSS); and~~

~~(D) Development Disabilities Services Division (DDSD).~~

**340:1-1-18. Strategic planning [REVOKED]**

~~(a) **Strategic planning.** Strategic planning:~~

~~(1) is an ongoing process that assists the Director of Oklahoma Department of Human Services (OKDHS) in managing the activities of OKDHS to support the OKDHS mission;~~

~~(2) allows OKDHS to be more responsive in a rapidly changing environment;~~

~~(3) uses organizational assessments to provide the foundation for the development and implementation of strategy; and~~

~~(4) assists OKDHS leadership, including the Director, Oklahoma Commission for Human Services (Commission), and executive team in establishing the mission, values, and vision.~~

~~(A) Organizational divisions collaborate to identify relevant goals and objectives based on organizational competencies and mandates.~~

~~(B) All core activities of OKDHS are aligned to implement the mission of OKDHS.~~

~~(b) **The OKDHS mission describes the purpose of the agency.** The OKDHS mission is to help individuals and families in need help themselves lead safer, healthier, more independent and productive lives. The Commission reaffirmed the mission on June 12, 2007.~~

~~(c) **The OKDHS values describe the manner in which staff strives to work.** The OKDHS values and guiding principles, approved by the Commission on June 12, 2007, are described in (1) through (5).~~

~~(1) Safety. We protect and serve vulnerable adults and children and reduce the risk of harm to individuals and families.~~

~~(2) Respect. We treat everyone with courtesy, promote mutual respect, and honor individual and cultural differences.~~

~~(3) Family.~~

~~(A) We build on the strengths in each family.~~

~~(B) Healthy families are the foundation of a healthy society.~~

~~(4) Relationships. We promote honest, dependable, and compassionate relationships and partnerships to build healthy families and communities.~~

~~(5) Excellence. We deliver prompt, accurate and courteous service in a fiscally responsible manner.~~

~~(d) **The OKDHS vision describes the business direction of the agency.** OKDHS promotes:~~

~~(1) an engaged local community.~~

~~(A) A community is a place or group of people that promotes individual responsibility and the shared responsibility for the care of its vulnerable members. Interdependent, trustworthy relationships form healthy communities that meet the needs of its members.~~

~~(B) OKDHS will be a trustworthy, dependable, participating member of the communities we serve. The healthy relationships we develop promote individual, family, and child well-being. OKDHS will be flexible in the development and delivery of meaningful services;~~

~~(2) creative solutions to complex challenges. OKDHS will continually seek new solutions that help the individuals and families we serve;~~

~~(3) a technological advantage. OKDHS will operate with greater knowledge, efficiency and effectiveness through improved technological solutions that add value to services and reduce costs;~~

~~(4) positive outcomes. OKDHS will equip individuals and families to make life choices that help them lead safer, healthier, more independent and productive lives through education and training; and~~

~~(5) partnerships with others. OKDHS will partner with public and private organizations to produce the best outcomes possible for the individuals and families we serve.~~

~~(e) **Goals.** OKDHS goals are developed to focus all activities of the agency toward attaining the OKDHS mission, values, and vision. Goals are projected for long term outcomes and reviewed annually by the Director to ensure their continued appropriateness. Identified changes in the OKDHS goals are submitted to the Commission for approval. Outcome measures are identified for each goal and approved by the Director. Targets are set for critical success measures, which are tracked on a monthly basis.~~

~~(f) **Key indicators.** Key indicators are performance measures for OKDHS business functions. Each division director or designee is responsible for establishing key indicators and setting targets against which performance is measured. The Director conducts a quarterly review of key indicator performance.~~

**340:1-1-19. Open Meeting Act**

~~All meetings of the~~ Oklahoma Department of Human Services (OKDHS) public meetings are conducted in compliance with the Oklahoma Open Meeting Act. [25 O.S. § 301 through 314] The ~~Office of Communications~~Oklahoma Secretary of State website serves as the open meeting clearinghouse ~~for all open meetings and has the responsibility to file the proper notices with the Secretary of State~~.

*[OAR Docket #13-885; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 2. ADMINISTRATIVE COMPONENTS

*[OAR Docket #13-887]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. Human Resources Management Division (HRMD)
Part 5. Administrative Procedures
340:2-1-57 [REVOKED]
**(Reference APA WF 12-04)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes; and the Governor's Executive Order number 2012-10, signed February 6, 2012.
**DATES:**
**Comment period:**
February 1, 2013 through March 4, 2013
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None requested
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Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
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July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
**Superseded rules:**
Subchapter 1. Human Resources Management Division (HRMD)
Part 5. Administrative Procedures
340:2-1-57 [REVOKED]
**(Reference APA WF 12-04)**
**Gubernatorial approval:**
June 28, 2012
**Register publication:**
29 Ok Reg 1795
**Docket number:**
12-840

**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed revision to Subchapter 1 of Chapter 2 revokes OAC 340:2-1-57 as it does not comply with the Governor's Executive Order number 2012-01, signed February 6, 2012.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. HUMAN RESOURCES MANAGEMENT DIVISION (HRMD)

## PART 5. ADMINISTRATIVE PROCEDURES

### 340:2-1-57. Tobacco policy [REVOKED]

~~In all buildings, offices, and facilities owned, leased, or otherwise occupied by the Oklahoma Department of Human Services (OKDHS), tobacco use is not permitted except in designated areas if available.~~

~~(1) **Outside use of tobacco.** Possession of tobacco in any form within 25 feet of the entrance or exit of any building, office, or facility owned, leased or otherwise occupied by OKDHS is prohibited.~~

~~(2) **Designation of tobacco use areas.** If adequate space exists, the Support Services Division (SSD) director may designate at least one tobacco use area in each building or facility. These areas must be adequately vented to the outside to eliminate smoke in both smoking and nonsmoking areas. SSD determines if adequate space exists and whether ventilation is sufficient to allow an area to be designated for smoking. Tobacco use areas are not used for public business.~~

~~(3) **State vehicles.** All state vehicles owned, leased, or otherwise utilized by OKDHS are considered a non-tobacco use area.~~

~~(4) **Responsibilities.** Administrators and supervisors are responsible for the enforcement of this policy. Appropriate signs such as "No Tobacco Use Within 25 feet of Building" are posted.~~

*[OAR Docket #13-887; filed 5-22-13]*

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# TITLE 340. DEPARTMENT OF HUMAN SERVICES
# CHAPTER 2. ADMINISTRATIVE COMPONENTS

*[OAR Docket #13-892]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Office of Client Advocacy
Part 1. Administration
340:2-3-2 [AMENDED]
Part 3. Investigations
340:2-3-33 through 340:2-3-34 [AMENDED]
**(Reference WF12-09)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes (10A O.S. § 162); 10A O.S. § 1-1-101 et seq.; 43A § 10-102 et. seq.; and Section 5101 et seq. of Title 42 of the United States Code.
**DATES:**
**Comment period:**
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None requested
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n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed amendments to Chapter 2 Subchapter 3 amend the rules to: (1) comply with statutory changes effective January 1, 2013, created as a result of the child welfare lawsuit settlement and related Oklahoma Department of Human Services (OKDHS) Pinnacle Plan; and (2) reflect clarification on processing grievances.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. OFFICE OF CLIENT ADVOCACY

## PART 1. ADMINISTRATION

**340:2-3-2. Definitions**

The following words and terms when used in this Subchapter shall have the following meanings, unless the context clearly indicates otherwise~~.~~:

**"Abandonment"** means the willful intent by words, actions, or omissions of the person responsible for the child (PRFC) not to return for a child or as defined per OAC 340:75-3-120.

**"Abuse"** means, with regard to:

(A) ~~minors~~children and youth, harm or threatened harm or failure to protect from harm or threatened harm to the health, safety, or welfare of a child by a person responsible for the child's health, safety, or welfare, including but not limited to:

(i) non-accidental physical injury or mental injury; or

(ii) sexual abuse; or

(iii) sexual exploitation; or

(B) vulnerable adults, causing or permitting the:

(i) infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish; or

(ii) deprivation of nutrition, clothing, shelter, health care, or other care or services by a caretaker or other person providing services to a vulnerable adult without which serious physical or mental injury is likely to occur to a vulnerable adult ~~by a caretaker or other person providing services to a vulnerable adult~~.

**"Administrator~~,~~"**~~including the person designated by an administrator to act on the administrator's behalf,~~or designee means, with regard to:

(A) ~~minors~~children in Oklahoma Department of Human Services (OKDHS) custody living in a private residential facility, the chief administrative officer of the facility;

(B) ~~minors~~children in OKDHS custody in an OKDHS operated shelter or group home, the director of the shelter or group home;

(C) ~~minors~~children in OKDHS custody and youth in voluntary care of OKDHS who live in any other setting, including any type of out-of-home placement, the applicable OKDHS ~~county~~district director;

(D) foster parents, the applicable OKDHS ~~county~~district director or ~~area~~deputy director~~, as appropriate~~;

(E) ~~minors~~children and youth in residential care facilities operated by Office of Juvenile Affairs (OJA) or Oklahoma Department of Rehabilitation Services (ODRS), facilities ~~which~~that contract with or are licensed by OJA, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the J.D. McCarty Center, or OKDHS, and other residential care facilities, the superintendent, director, chief administrative officer, or head of the facility regardless of the person's working title;

(F) day treatment programs, the person charged with responsibility for administering the program;

(G) adults and ~~minors~~children who are in Developmental Disabilities Services Division (DDSD) specialized foster care and DDSD specialized foster parents, the applicable DDSD area manager;

(H) residents of Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Robert M. Greer Center (Greer), the facility director;

(I) providers of residential services, vocational services, or in-home paraprofessional supports to individuals with developmental disabilities living in the community, the chief executive officer of the provider; and

(J) residents of group homes for persons with developmental disabilities, the director of the group home.

**"Adult Protective Services"** or **"APS"** means the Adult Protective Services Unit of OKDHS.

**"Advocate"** means an Office of Client Advocacy (OCA) employee who provides assistance to OCA clients in exercising their rights, listening to their concerns, encouraging them to speak for themselves, seeking to resolve problems, helping protect their rights, and seeking to improve the quality of their life and care.

**"Advocate general"** means the OCA chief administrative officer ~~of the OCA~~ designated in Section 1-9-112(A)(2) of Title 10A of the Oklahoma Statutes (10A O.S. § 1-9-112(A)(2)). ~~The email address for the advocate general is oca.advocate-general@okdhs.org.~~

**"Authorized use of physical force"** by a ~~caretaker~~PRFC of ~~minors and youths~~a child residing outside ~~their homes~~the child's home, other than ~~minors and youth~~a child in foster care means:

(A) the use of physical contact to control or contain a person when the ~~caretaker~~ PRFC reasonably considers that person to:

(i) pose a risk of inflicting harm to self or others; or

(ii) be in the process of leaving a facility without authorization; and

(B) when the use of physical force is authorized, the least force necessary under the circumstances is employed. In determining whether excessive force has been used, all of the circumstances surrounding the incident are taken into consideration, including the:

(i) ~~the~~ grounds for belief that force was necessary;

(ii) ~~the~~ age, gender, and strength of the parties involved;

(iii) ~~the~~ nature of the force employed;

(iv) ~~the~~ availability of alternative means of force or control; and

(v) ~~the~~ extent of the harm inflicted.

**"Behavioral health"** means mental health, substance abuse, or co-occurring mental health and substance abuse diagnoses, and the continuum of mental health, substance

abuse, or co-occurring mental health and substance abuse treatment.

**"Caretaker"** means, with regard to~~:~~

~~(A) minors and youth, a person responsible for a child's health, safety, or welfare who is an agent or employee of:~~

~~(i) a public or private residential home, institution, or facility above the level of foster family care; or~~

~~(ii) a day treatment program as defined in 10 O.S. § 175.20; and~~

~~(B)~~ vulnerable adults, a person who has:

(~~i~~A) the responsibility for the care of a vulnerable adult or the financial management of the resources of a vulnerable adult as a result of a family relationship;

(~~ii~~B) assumed the responsibility for the care of a vulnerable adult voluntarily, by contract, or as a result of the ties of friendship; or

(~~iii~~C) been appointed a guardian, limited guardian, or conservator pursuant to the Oklahoma Guardianship and Conservatorship Act.

**"Caretaker misconduct"**:

(A) means an act or omission that:

(i) violates a statute, regulation, written rule, procedure, directive, or accepted professional standards and practices;

(ii) is not found to be abuse or neglect; and

(iii) results in, or creates the risk of harm to a ~~minor~~child, or a vulnerable adult residing at ~~the Southern Oklahoma Resource Center (~~SORC~~)~~, the ~~Northern Oklahoma Resource Center of Enid (~~NORCE~~)~~, or ~~the Robert M. Greer Center (~~Greer~~).~~; and

(B) includes, but is not limited to:

(i) acts or omissions that contribute to the delinquency of a ~~minor~~child;

(ii) unintentional excessive or unauthorized use of force not rising to abuse or neglect;

(iii) unintentionally causing mental anguish;

(iv) other acts exposing a client to harm or threatened harm to the health, safety, or welfare of the client; or

(v) use of abusive or professionally inappropriate language not rising to the level of verbal abuse.

**"Case manager"** means the person assigned by DDSD who has ~~the~~ responsibility for ensuring that services to an individual are planned and provided in a coordinated fashion.

**"Child"** means any unmarried person under 18 years of age, except any person convicted of a crime specified in 10A O.S. § 2-5-101 or any person certified as an adult pursuant to 10A O.S. § 2-2-403 and convicted of a felony.

**"Child placing agency"** means an agency that provides social services to children and their families that supplement, support, or substitute parental care and supervision for the purpose of safeguarding and promoting the welfare of children. The agency may provide full time placement services for children away from their own homes, such as adoptive homes, foster family homes, group homes, and transitional or independent living programs.

**"Child with a disability"** means any child who has a physical or mental impairment that substantially limits one or more of the major life activities of the child, or who is regarded as having such impairment by a competent medical professional.

**"Client"** means, with regard to OCA:

(A) investigation services, those individuals listed in OAC 340:2-3-32(a)(2);

(B) grievance services, those individuals listed in OAC 340:2-3-45(a)(2); and

(C) advocacy program, those individuals listed in OAC 340:2-3-71(b).

**"Community-based services"** or **"community-based programs"** means services or programs that maintain community participation or supervision in planning, operation, and evaluation. Community-based services and programs may include, but are not limited to:

(A) case supervision;

(B) consultation;

(C) counseling;

(D) crisis intervention;

(E) early intervention and diversionary substance abuse treatment;

(F) educational;

(G) emergency shelters;

(H) group work;

(I) home-based services;

(J) independent living;

(K) job placement;

(L) medical;

(M) sexual abuse treatment;

(N) training;

(O) transitional living;

(P) vocational, social, preventive, and psychological guidance;

(Q) volunteer recruitment and training; and

(R) other related services and programs.

**"Community services worker"** or **"CSW"** means any person:

(A) ~~any person not~~other than a licensed health professional who is employed by or under contract with a community services provider to provide, for compensation or as a volunteer, health-related services, training, or supportive assistance as ~~those terms are~~ defined in 56 O.S. § 1025.1, to persons with developmental disabilities; or~~.~~

(B) who contracts with the Oklahoma Health Care Authority to provide specialized foster care, habilitation training specialist services, or homemaker services, to persons with developmental disabilities.

**"Community Services Worker Registry"** or **"CSW Registry"** means the Community Services Worker Registry established by OKDHS ~~in accordance with~~per 56 O.S. § 1025.3.

**"Custodian"** means an individual other than a parent, legal guardian, or Indian custodian, to whom legal custody of

the child has been awarded by the court. The term "custodian" does not mean OKDHS.

**"Day treatment program"** means a non-residential, partial hospitalization program, day treatment program, or day hospital program ~~in which minors~~where children are provided intensive services, psychiatric~~,~~ or psychological treatment.

**"DDSD"** means ~~the~~OKDHS Developmental Disabilities Services Division ~~of OKDHS~~.

**"DHS"** or **"Department"** or **"OKDHS"** means the Oklahoma Department of Human Services.

**"Disposition~~,~~"**means with regard to OCA intake processes, ~~means~~ the action taken by the OCA intake unit in response to a referral received, ~~pursuant to~~per OAC 340:2-3-35.

**"DMHSAS"** or **"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"DRS"** means the Oklahoma Department of Rehabilitation Services.

**"Email"** means:

(A) with regard to the advocate general, an email sent to oca.advocategeneral@okdhs.org;

(B) with regard to OCA grievance matters, an email sent to oca.advocategeneral@okdhs.org;

(C) with regard to OCA investigation matters, an email sent to oca.advocategeneral@okdhs.org; and

(D) with regard to OCA intake matters, oca.advocategeneral@okdhs.org.

**"Emergency"** means a situation in which a person is likely to suffer death or serious physical harm without immediate intervention.

**"Emergency custody"** means court-ordered custody of a child prior to adjudication of the child.

**"Excessive use of force"** by a ~~caretaker~~PRFC, with regard to ~~minors~~children and ~~youths~~ youth residing outside their homes, other than ~~minors~~children and youth in foster care, means the failure to employ the least amount of physical force necessary under the circumstances, taking into consideration all of the circumstances surrounding the incident, including the:

(A) ~~the~~ grounds for belief that force was necessary;

(B) ~~the~~ age, gender, and strength of the parties involved;

(C) ~~the~~ nature of the force employed;

(D) ~~the~~ availability of alternative means of force or control;

(E) ~~the~~ extent of the harm inflicted; and

(F) ~~the~~ method(s) of restraint and intervention approved for use with the person against whom the force was used.

**"Exploitation"** or **"exploit"** with regard to vulnerable adults, means an unjust or improper use of the resources of a vulnerable adult for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable adult through the use of undue influence, coercion, harassment, duress, deception, false representation, or false pretense.

**"Facility"** means:

(A) a public or private agency, corporation, partnership, or other entity ~~which~~that:

(i) operates a residential child care center; or

(ii) contracts with or is licensed or funded by OKDHS, OJA, or ODMHSAS for the physical custody, detention, or treatment of ~~minors~~children;

(B) an OKDHS operated shelter;

(C) an OKDHS, OJA, ODMHSAS, or DRS operated residential child care center;

(D) a community-based youth services shelter or community intervention center;

(E) the J.D. McCarty Center;

(F) a day treatment program;

(G) a private psychiatric facility for ~~minors~~children;

(H) sanctions programs certified by OJA to provide programming for ~~minors~~children who are court ordered to participate in that program; or

(I) SORC, NORCE, and Greer.

**"Financial neglect"** with regard to vulnerable adults, means repeated instances by a caretaker, or other person, who has assumed the role of financial management, of failure to use the resources available to restore or maintain the health and physical well-being of a vulnerable adult, including, but not limited to:

(A) squandering or negligently mismanaging the money, property, or accounts of a vulnerable adult;

(B) refusing to pay for necessities or utilities in a timely manner; or

(C) providing substandard care to a vulnerable adult despite the availability of adequate financial resources.

**"Foster care"** or **"foster care services"** means continuous 24-hour care and supportive services provided for an individual in a foster placement~~,~~ including, but not limited to the care, supervision, guidance, and rearing of a foster child by the foster parent.

**"Foster child"** means a child placed in a foster family placement.

**"Foster parent"** means ~~an individual~~any person maintaining a therapeutic, emergency, specialized community home, tribal, kinship, or foster family home, who is responsible for ~~the~~ providing care, supervision, guidance, rearing, and other foster care services ~~provided~~ to ~~another individual~~a child.

**"GARC"** means the Grievance and Abuse Review Committee described in OAC 340:2-3-61.

**"Group home"** means an OKDHS licensed residential facility that provides full-time care and community-based services for more than five but fewer than 13 children.

**"Group home for persons with developmental or physical disabilities"** means any establishment:

(A) for not more than 12 residents who:

(i) are 18 years of age or older; and

(ii) have developmental or physical disabilities;

(B) that offers or provides supervision, residential accommodations, food service, and training and skill development opportunities designed to lead to increased independence of the residents and supportive assistance to any of the residents requiring supportive assistance; and

(C) that is not:

(i) a residential care home;

(ii) a nursing facility;

(iii) an assisted living facility;

(iv) a home in which agency companion services or specialized foster care is provided; or

(v) a home owned or leased by the service recipient or his or her legal guardian.

**"Guardian"** means a person appointed by a court to ensure that the essential requirements for the health and safety of an incapacitated or partially incapacitated person, the ward, are met, to manage the estate or financial resources of the ward, or both. As used in this Subchapter, guardian includes: a general or limited guardian of the person; a general or limited guardian of the estate; a special guardian; and a temporary guardian. The term does not include a person appointed as guardian ad litem.

**"Guardian ad litem"** or **"GAL"** means a person appointed by a court, pursuant to 10 O.S. § 1415, to represent the interests of an individual as specified in the court order.

**"Harm or threatened harm to the health, safety, or welfare"** means, with regard to ~~minors~~children and youth, any real or threatened physical, mental, or emotional injury or damage to the body or mind that is not accidental~~,~~ including, but not limited to, sexual abuse, sexual exploitation, neglect, or dependency.

**"Heinous and shocking abuse"** includes, but is not limited to, aggravated physical abuse that results in serious bodily, mental, or emotional injury. "Serious bodily injury" means injury that involves:

(A) a substantial risk of death;

(B) extreme physical pain;

(C) protracted disfigurement;

(D) a loss or impairment of the function of a body member, organ, or mental faculty;

(E) an injury to an internal or external organ or the body;

(F) a bone fracture;

(G) sexual abuse or sexual exploitation;

(H) chronic abuse including, but not limited to, physical, emotional, or sexual abuse, or sexual exploitation that is repeated or continuing;

(I) torture that includes, but is not limited to, inflicting, participating in or assisting in inflicting intense physical or emotional pain upon a child repeatedly over a period of time for the purpose of coercing or terrorizing a child or for the purpose of satisfying the craven, cruel, or prurient desires of the perpetrator or another person; or

(J) any other similar aggravated circumstance.

**"Heinous and shocking neglect"** includes, but is not limited to:

(A) chronic neglect that includes, but is not limited to, a persistent pattern of family functioning in which the caregiver has not met or sustained the basic needs of a child that results in harm to the child;

(B) neglect that has resulted in a diagnosis of the child as a failure to thrive;

(C) an act or failure to act by a parent that results in the death or near death of a child or sibling, serious physical or emotional harm, sexual abuse, sexual exploitation, or presents an imminent risk of serious harm to a child; or

(D) any other similar aggravating circumstance.

**"Hissom class member"** means an individual certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in Homeward Bound, Inc., et al. vs. Hissom Memorial Center, et al., Case No. ~~85-C-437-TCK-SAJ~~85-CV-437-GKF.

**"Hotline"** means the statewide Oklahoma Abuse and Neglect Hotline, toll free ~~hotline~~, 1-800-522-3511, maintained by OKDHS for the purpose of receiving reports of abuse, neglect, or exploitation of children and adults. The hotline is in operation 24 hours a day, ~~7~~seven days a week.

**"ICF/~~MR~~ID"** or **"Intermediate Care Facility for the ~~Mentally Retarded,~~Intellectually Disabled,"** also known as a "specialized facility for the ~~mentally retarded~~intellectually disabled," means a private or public residential facility, licensed in accordance with state law and certified by the federal government as a provider of Medicaid services, for mentally retarded persons as that term is defined in Title XIX rules and regulations of the Social Security Act.

**"Incapacitated person"** means:

(A) ~~any~~a person 18 years of age or older who is impaired by reason of mental or physical illness or disability, dementia, or related disease, ~~mental retardation~~ intellectual disability, developmental disability, or other cause, and whose ability to receive and evaluate information effectively or to make and ~~to~~ communicate responsible decisions is impaired to such an extent that the person lacks the capacity to manage financial resources or ~~to~~ meet essential requirements for mental or physical health or safety without assistance from others; or

(B) a person for whom a guardian, limited guardian, or conservator has been appointed pursuant to the Oklahoma Guardianship and Conservatorship Act (Title 30 of the Oklahoma Statutes).

**"Indecent exposure"** means forcing or requiring a vulnerable adult to:

(A) look upon the body or private parts of another person or upon sexual acts performed in the presence of the vulnerable adult; or

(B) touch or feel the body or private parts of another.

**"Infant"** means a child 12 months of age or younger.

**"In-home supports"**~~and~~or**"IHS"** means services funded through Medicaid Home and Community-Based Waivers (HCBW) as defined in Section 1915(c) of the Social Security Act and administered by OKDHS DDSD~~, which~~that are provided in the service recipient's home and are not residential services as defined in OAC 340:100-5-22.1 or group home services as defined in 10 O.S. § 1430.2.

**"Injury"** means any hurt, harm, appreciable physical pain, or mental anguish.

**"Investigation"** means, regarding a:

(A) child, a response to an allegation of abuse or neglect that involves a serious and immediate threat to the safety of a child, making it necessary to determine:

(i) the current safety of the child and the risk of subsequent abuse or neglect; and

(ii) whether abuse or neglect of the child occurred; or

(B) vulnerable adult, a response to an allegation of abuse, neglect, verbal abuse, financial neglect, or exploitation of a vulnerable adult, making it necessary to determine whether maltreatment of the vulnerable adult occurred.

**"Investigative results"** means a written response stating one of the following findings:

(A) regarding a child:

(i) "substantiated" means OCA has determined, after an investigation of a report of child abuse or neglect of a child, and based upon some credible evidence, that child abuse or neglect occurred;

(ii) "unsubstantiated" means OCA has determined, after an investigation of a report of child abuse or neglect of a child, that insufficient evidence exists to fully determine whether child abuse or neglect occurred; or

(iii) "ruled out" means OCA has determined, after an investigation of a report of child abuse or neglect of a child that no child abuse or neglect occurred.

(B) regarding a vulnerable adult:

(i) "substantiated" means that the greater weight of the available evidence establishes the alleged maltreatment occurred;

(ii) "not substantiated" means the greater weight of the available evidence indicates the alleged maltreatment did not occur;

(iii) "ruled out" means no evidence was discovered that indicates the alleged maltreatment occurred; or

(iv) "defer" means OCA will defer the completion of an investigation and the issuance of a finding upon reasonable request to do so by a law enforcement agency having investigative authority.

**"Maltreatment"** means abuse, verbal abuse, sexual abuse, neglect, financial neglect, exploitation or sexual exploitation of vulnerable adults as defined in 43A O.S. § 10-103; or abuse, neglect, sexual abuse or sexual exploitation of children as defined in 10A O.S. § 1-1-105.

**"Medicaid personal care assistant"** or **"MPCA"** means a person who provides Medicaid services funded under Oklahoma's personal care program who is not a certified nurse aide or a licensed professional.

**"Mental anguish"** means mental damage evidenced by distress, depression, withdrawal, severe anxiety, or unusually aggressive behavior toward self or others.

**"Mental health facility"** means a mental health or substance abuse treatment facility as defined by the Inpatient Mental Health and Substance Abuse Treatment of Minors Act as defined in 43A O.S. § 5-502(10).

~~**"Minor"** means any person under 18 years of age except any person convicted of a crime specified in 10A O.S. § 2-5-101 or any person certified as an adult pursuant to 10A O.S. § 2-2-403 and convicted of a felony.~~

**"Minor physical injury"** means a demonstrable injury reasonably expected to be treated with the administration of first aid, over the counter remedies, or both. A demonstrable injury includes damage to bodily tissue caused by non-therapeutic conduct, illness, new or an increased impairment of physical or cognitive functioning, evidence of a physical injury ~~(for example~~such as, a laceration, bruise, or burn~~)~~, and an injury ~~which is~~ confirmed by a physician, dentist, nurse, or other health care professional.

**"Multidisciplinary child abuse team"** means any team established pursuant to 10A O.S. § 1-9-102 of three or more persons who are trained in the prevention, identification, investigation, prosecution, and treatment of physical and sexual child abuse and who are qualified to facilitate a broad range of prevention and intervention-related services and services related to child abuse. For purposes of this definition, "freestanding" means a team not used by a child advocacy center for its accreditation.

**"Near death"** means a child is in serious or critical condition as verified by a physician, a registered nurse, or other licensed health care provider. Verification of medical condition of a child may be given in person or by telephone, mail, electronic mail, or facsimile.

**"Neglect"** means, with regard to:

(A) ~~minors~~children and youth:

(i) the failure or omission to provide any of the following:

(I) adequate nurturance and affection, food, clothing, shelter, sanitation, hygiene, or appropriate education;

(II) medical, dental, or behavioral health care;

(III) supervision or appropriate caretakers; or

(IV) special care made necessary by the physical or mental condition of the child;

(ii) the failure or omission to protect a child from exposure to any of the following:

(I) the use, possession, sale, or manufacture of illegal drugs;

(II) illegal activities; ~~or~~

(III) sexual acts or materials that are not age-appropriate; or

(iii) abandonment; or

(B) vulnerable adults:

(i) the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest;

(ii) the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing; or

(iii) negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services.

**"OCA"** means the OKDHS Office of Client Advocacy ~~of OKDHS~~.

**"OCA intake"** means the centralized intake system maintained by OCA ~~in its Oklahoma City office~~ that receives referrals of alleged abuse, neglect, verbal abuse, financial neglect, and financial exploitation involving vulnerable adults.

**"OJA"** means the Oklahoma Office of Juvenile Affairs.

**"Ombudsman"** or **"ombuds,"** means "advocate" as defined in this ~~subsection~~ Section.

**"Person responsible for the child (PRFC)"** means a person responsible for a child's health, safety, or welfare who is an agent or employee of:

(A) a public or private residential home, institution, or facility above the level of foster family care;

(B) a day treatment program per 10 O.S. § 175.20; or

(C) an owner, operator, or employee of a child care facility per 10 O.S. § 402.

**"Person responsible for the child of interest (PRFCI)"** means a person responsible for the child who is the subject of an investigation involving allegations of abuse or neglect.

**"Personal support team"** or **"team,"** formerly known as the "interdisciplinary team," means the decision-making body for service planning, implementation, and monitoring of the individual plan, as more fully described in OAC 340:100-5-52.

**"Preponderance of the evidence"** means information or evidence that is of a greater weight or more convincing than the information or evidence offered in opposition. It is that degree of proof ~~which~~that is more probable than not.

**"Problem resolution"** means verbal or written communications ~~which~~that seek to resolve concerns, complaints, service inadequacies, or issues identified by the client or members of the client's team, including the client's guardian, the OCA advocate for the client, a volunteer advocate for the client, or other persons interested in the welfare of the client.

**"Protective custody"** means custody of a child taken by law enforcement or designated employee of the court, without a court order.

**"Provider"** means a program, corporation, partnership, association, individual, or other entity that contracts with, or is licensed or funded by, OKDHS to provide community-based residential or vocational services to persons with ~~mental retardation~~intellectual or developmental disabilities, or ~~which~~ contracts with the Oklahoma Health Care Authority to provide residential or vocational services or in-home supports to individuals with ~~mental retardation~~intellectual disabilities through the Home and Community-Based Waiver.

**"Referring party"** means the individual who informs OCA or Hotline verbally or in writing that an incident occurred.

**"Reporting party"** means the individual who initially tells someone verbally or in writing that an incident occurred.

**"Residential child care ~~center~~facility"** means a 24-hour-a-day residential group care facility at which a specified number of ~~minors~~children, normally unrelated, reside with adults other than their parents.

**"Risk"** means the likelihood that an incident of child abuse or neglect will occur in the future.

**"Safety analysis"** means action taken by OKDHS in response to a report of alleged child abuse or neglect that may include an assessment or investigation based upon an analysis of the information received according to OKDHS adopted priority guidelines and other criteria.

**"Safety evaluation"** means an OKDHS evaluation of a child's situation using a structured, evidence-based tool to determine if the child is subject to a safety threat.

**"Safety threat"** means the threat of serious harm due to child abuse or neglect occurring in the present or in the very near future and without the intervention of another person, a child would likely or in all probability sustain severe or permanent disability or injury, illness, or death.

**"Secure facility"** means a facility that is designed and operated to ensure that all entrances and exits from the facility are subject to the exclusive control of the staff of the facility, whether or not the juvenile being detained has freedom of movement within the perimeter of the facility, or a facility that relies on locked rooms and buildings, fences, or physical restraint in order to control resident behavior.

**"Self-neglect"** means the action or inaction of a vulnerable adult ~~which~~that causes ~~that~~the person to fail to meet the essential requirements for physical or mental health and safety due to the vulnerable adult's lack of awareness, incompetence, or incapacity.

**"Serious physical injury"** means a physical injury to a person's body determined to be serious by a physician, dentist, or nurse. It includes, but is not limited to, death, suicide attempt, fracture, dislocation of any major joint, internal injury, concussion, head injury with loss of consciousness, ingestion of foreign substances and objects that are harmful; near drowning, lacerations involving injuries to tendons or organs and those for which complications are present, lacerations requiring four or more stitches or staples to close, heat exhaustion or heatstroke, injury to an eyeball, irreversible loss of mobility, permanent damage to or loss of a tooth, skin deterioration, and a second or third degree burn and other burns for which complications are present. It also includes multiple abrasions, bruises, and minor physical injuries on the body of a person, identified around the same time or over a period of several weeks~~, that have no~~without a clear, known explanation.

**"Sexual abuse"** means, with regard to:

(A) ~~minors~~children and youth, rape, incest, and lewd or indecent acts or proposals, as defined by state law, by a ~~caretaker responsible for the health, safety, or welfare of the minor or youth~~person; or

(B) vulnerable adults:

(i) oral, anal, or vaginal penetration of a vulnerable adult by or through the union with the

sexual organ of a caretaker or other person providing services to the vulnerable adult, or the anal or vaginal penetration of a vulnerable adult by a caretaker or other person providing services to the vulnerable adult with any other object;

(ii) for the purpose of sexual gratification, the touching, feeling or observation of the body or private parts of a vulnerable adult by a caretaker or other person providing services to the vulnerable adult; or

(iii) indecent exposure by a caretaker or other person providing services to the vulnerable adult.

**"Sexual exploitation"** means, with regard to:

(A) ~~minors~~children and youth allowing, permitting:

(i) ~~allowing, permitting,~~ or encouraging a ~~minor~~child or youth to engage in sexual acts with others or prostitution, as defined by state law, by a ~~caretaker~~ person responsible for the ~~minor~~child's or youth's health, safety, or welfare; or

(ii) ~~allowing, permitting,~~ encouraging, or engaging in the lewd, obscene, or pornographic photographing, filming, or depicting of a ~~minor~~child or youth in those acts as defined by ~~the~~ state law~~,~~or by a ~~caretaker responsible for the minor's health, safety, or welfare~~person; or

(B) vulnerable adults, includes, but is not limited to, a caretaker's causing, allowing, permitting, or encouraging a vulnerable adult to engage in prostitution or in the lewd, obscene, or pornographic photographing, filming, or depiction of the vulnerable adult as those acts are defined by state law.

**"Specialized foster care"** means foster care provided to a ~~minor~~child or adult in a DDSD certified and monitored specialized foster ~~home~~ or agency-contracted home ~~which has been certified by DDSD, is monitored by DDSD, and is~~ funded through the DDSD administered~~Home and Community-Based Waiver~~HCBW Services Program ~~administered by DDSD~~.

**"State office"** means the administrative offices of OKDHS in Oklahoma City.

**"State office administrator~~,~~"** including the person designated by a state office administrator to act on the state office administrator's behalf, means, with regard to:

(A) grievances of ~~minors~~children, youths, and foster parents regarding the substance or application of any policy, rule, or regulation, written or unwritten, of OKDHS or an OKDHS operated shelter or residential facility, or of an agent or ~~contractor of~~ OKDHS contractor~~,~~ or ~~a~~ child placement agency, or the ~~director of~~ OKDHS ~~Children and Family Services Division (CFSD)~~Child Welfare Services (CWS) director;

(B) grievances regarding a decision, behavior, or action by an OKDHS employee, agent, contractor, foster parent, or ~~by~~ any person residing in the same placement setting, the ~~director of the~~ OKDHS ~~Field Operations Division~~CWS director;

(C) DDSD clients~~, the~~and director ~~of DDSD~~; and

(D) other OKDHS clients, and the appropriate chief officer or ~~division~~ director.

**"Subpoena"** means a command to appear at a certain time and place to give testimony. A "subpoena duces tecum" is a command requiring the person subpoenaed to bring records or other designated items with them.

**"Suspicious injury"** means an injury ~~for which there is no credible explanation~~ that ~~makes it unlikely to be the result of client maltreatment.~~:

(A) ~~It~~ includes, but is not limited to, an injury that:

(i) appears inconsistent with the offered explanation(s) for the injury;

(ii) is unusual;

(iii) cannot be explained as the result of an accident, self-injurious behavior, or normal activities of daily living;

(iv) is a minor injury located on or near a private part of the body or on a part of the body that makes it unlikely to have been the result of self-injury or an accident during the course of daily living activities; and

(v) involves multiple abrasions, bruises, and minor injuries on the body of a person, identified around the same time or over a period of several weeks, but have no clear, known explanation.

(B) The determination whether an injury is suspicious is made from the point of view of an independent skeptical reviewer. An injury is suspicious if there is no credible explanation for it consistent with the injury not being the result of maltreatment.

**"Unauthorized use of force"** means, with regard to ~~minors~~children and ~~youths~~youth residing outside their homes, other than ~~minors~~children and youth in foster care, a use of force that is not an authorized use of physical force as defined in this ~~subsection~~Section. It includes unacceptable physical handling of, and contact with clients including, but not limited to, slapping, kicking, punching, poking, pulling hair or an ear, pinching, using a chokehold, smothering, spitting, head butting, and tugging.

**"Unexplained injury"** means an injury for which there is no known credible origin or cause, even though a possible explanation for the injury may be offered.

**"Verbal abuse"** means the use of words, sounds, or other communication including, but not limited to, gestures, actions, or behaviors, by a caretaker or other person providing services to a vulnerable adult that are likely to cause a reasonable person to experience humiliation, intimidation, fear, shame or degradation.

**"Vulnerable adult"** means an individual who is an incapacitated person or who, because of physical or mental disability, incapacity, or other disability, is substantially impaired in the ability to:

(A) provide adequately for the care or custody of ~~himself~~him or herself;

(B) manage his or her property and financial affairs effectively;

(C) meet essential requirements for mental or physical health or safety; or

(D) protect ~~himself~~him or herself from abuse, verbal abuse, neglect, or exploitation without assistance from others.

**"Ward"** means a person over whom a guardianship has been given by the court.

**"Youth"** means, with regard to:

(A) OCA investigation programs, a person over 18 years of age in OJA custody ~~and~~ residing in an OJA operated facility or a facility ~~which~~that contracts with OJA; or

(B) OCA grievance programs, a person over 18 years of age in OJA custody or OKDHS voluntary care ~~of OKDHS~~.

## PART 3. INVESTIGATIONS

### 340:2-3-33. Procedure for reporting suspected abuse, neglect, verbal abuse, caretaker misconduct, and exploitation

~~(a) **Reporting requirements and reportable incidents.**~~ (a)~~(1)~~**Reporting abuse or neglect of a child under the age of 18 years.** Persons having reason to believe that a child under the age of 18 years is a victim of abuse or neglect are required by Section 1-2-101 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-2-101) to promptly report it to the Oklahoma Department of Human Services (OKDHS) Abuse and Neglect Hotline (Hotline) at 1-800-522-3511. Any allegation of abuse or neglect reported in any manner to a county office is immediately referred to the Hotline by OKDHS, per Section 10A O.S. § 1-2-101.

(b)~~(2)~~**Reporting abuse, neglect, verbal abuse, or exploitation of a vulnerable adult.**~~Persons having reason~~Any person having reasonable cause to believe that a vulnerable adult is a victim of abuse, neglect, ~~verbal abuse,~~ or exploitation ~~are required by 43A O.S. § 10-104 to promptly report it~~shall make a report as soon as the person is aware of the situation to OKDHS or the municipal police department or sheriff's office in the county where the suspected abuse, neglect, or exploitation occurred. ~~This~~The reporting requirement applies to providers, as defined in OAC 340:2-3-2, and ~~their~~the provider's employees and agents.

~~(3) Employees of OKDHS, Oklahoma Department of Rehabilitation Services (ODRS), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Office of Juvenile Affairs (OJA), and the J.D. McCarty Center~~

(c) **Reporting caretaker misconduct regarding a child or youth.** Persons who have reason to believe that caretaker misconduct, as defined in OAC 340:2-3-2, has occurred with regard to a child or youth,~~client has occurred~~ promptly refer ~~it~~the allegation to ~~OCA intake~~the OKDHS Abuse and Neglect Hotline. The Office of Client Advocacy (OCA) may conduct an investigation when the OKDHS Specialized Placement Unit, OKDHS Child Care Licensing, or another source determines a pattern of misconduct exists by a person responsible for the child of interest (PRFCI) or a facility, or facility administration fails to take appropriate corrective action.~~This referring requirement also extends to employees of private facilities that contract with OKDHS, ODRS, ODMHSAS, and OJA to provide residential services to these clients.~~

~~(4) A person may have reason to believe that maltreatment or caretaker misconduct has occurred based on information he or she has learned directly or indirectly, including information provided by the alleged victim or witnesses to an incident. When an allegation of maltreatment is made by the alleged victim or the guardian or parent of the alleged victim, it is referred to OCA intake. Persons unsure of what to report or to refer call OCA intake, 1-800-522-8014, during business hours, and after hours call the Abuse Hotline, 1-800-522-3511.~~

~~(5) Knowledge of circumstances that may constitute maltreatment is reported even if the person reporting it cannot substantiate the information.~~

(d) **Reporting caretaker misconduct regarding a vulnerable adult.** Persons who have reason to believe caretaker misconduct, as defined in OAC 340:2-3-2, has occurred with regard to a vulnerable adult residing at the Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Robert M. Greer Center (Greer), promptly refer the allegation to OCA intake.

(e~~6~~) **Reporting a vulnerable adult's death, serious physical injury, or sexual assault.** ~~In addition to the reportable incidents in paragraphs (1), (2), and (3) of this subsection, employees and agents of OKDHS, ODRS, ODMHSAS, OJA, the J.D. McCarty Center, facilities, and providers report to OCA events listed in (A) through (G) of this paragraph involving a person listed in OAC 340:2-3-32(a)(2)~~In addition to the mandatory reporting requirements per OAC: 340:2-3-33(b) the events listed in (1) through (7) of this subsection are reported to OCA intake when a vulnerable adult's caretaker is alleged to be involved in the vulnerable adult's:

(1~~A~~) ~~a~~ violent death, whether apparently homicidal, suicidal, or accidental;

(2~~B~~) ~~a~~ death under suspicious, unusual, or unnatural circumstances;

(3~~C~~) ~~the~~ death ~~of~~when the vulnerable adult is a resident of ~~the Southern Oklahoma Resource Center (~~SORC~~)~~, the ~~Northern Oklahoma Resource Center of Enid (~~NORCE~~)~~, or ~~the Robert M. Greer Center (~~Greer~~)~~;

(4~~D~~) ~~the~~ death ~~of~~when the vulnerable adult is a Hissom class member;

(5~~E~~) ~~a~~ serious physical injury, ~~as defined in~~per OAC 340:2-3-2;

(6~~F~~) ~~any~~ physical injury ~~if it~~when the injury is:

(A~~i~~) unexplained; and

(B~~ii~~) suspicious; or

(~~G~~7) rape, sodomy, or other sexual activity prohibited by state law.

~~(7) "Promptly" reporting as used in this Subchapter means the same day or the next working day.~~

~~(8) The reporting obligations under this Section are individual.~~

(f) **Interference, retaliation, or discrimination related to the reporting obligations required by the Oklahoma**

**Children's Code and the Protective Services for Vulnerable Adults Act prohibited.** ~~Employers, supervisors, and administrators do not impede~~

(1) Per 10A O.S. § 1-2-101, the reporting obligations under the Oklahoma Children's Code are individual and no employer, supervisor, or administrator interferes with the reporting obligations of any employee or other person or in any manner discriminate or retaliate against the employee or other person who in good faith reports suspected child abuse or neglect, or who provides testimony in any proceeding involving child abuse or neglect. Any employer, supervisor, or administrator who discharges, discriminates, or retaliates against the employee or other person is liable for damages, costs, and attorney fees.

(2) Per 43A O.S. § 10-104, no employer terminates the employment, prevents or ~~inhibit the reporting obligations~~impairs the practice, or occupation of, or imposes any other sanction on any employee solely for the reason the employee made or ~~other person~~caused to be made a report or cooperated with an investigation pursuant to the Protective Services for Vulnerable Adults Act.

~~(b)~~ ~~**Reporting responsibilities.**~~

~~(1)~~ ~~**Reportable incidents.**~~ ~~Reportable incidents are defined in subsection (a) of this Section.~~

~~(2)~~ ~~**Children and youth.**~~ ~~An OKDHS employee with knowledge of a reportable incident involving a child or youth who is an OCA client, as defined in OAC 340:2-3-32(a)(2), is required to make an immediate referral to OCA intake. Any other person who has knowledge of this type of reportable incident involving an OCA client is required by law to make a prompt report to OCA intake, Child Welfare in an OKDHS local county office, or the statewide, toll-free hotline (the "Abuse Hotline"), 1-800-522-3511. Referrals to OCA intake are made per subsection (e) of this Section.~~

~~(3)~~ ~~**Vulnerable adults.**~~ ~~An OKDHS employee who has knowledge of a reportable incident involving a vulnerable adult who is an OCA client, as defined in OAC 340:2-3-32(a), is required to make an immediate referral to OCA intake. Any other person who has knowledge of this type of reportable incident is required by law to make a report as soon as possible to OCA intake, or the local municipal police or sheriff's department.~~

(g~~4~~) **Immunity from liability for good faith report of abuse, neglect, or exploitation of a child or vulnerable adult.** ~~Oklahoma law provides that~~Per the Oklahoma Children's Code (10A O.S. § 1-2-104) and the Oklahoma Protective Services for Vulnerable Adults Act (43A O.S. § 10-104), any person exercising good faith and due care in making a report of alleged abuse, neglect, ~~verbal abuse,~~ or exploitation ~~pursuant to the Oklahoma Children's Code or the Oklahoma Protective Services for Vulnerable Adults Actshall have~~has immunity from any civil or criminal liability the person might otherwise incur. The person has the same immunity with respect to participation in any judicial proceeding resulting from the report.

~~(5)~~ ~~**Questions about reporting.**~~ ~~A person who is uncertain if a particular incident is reportable contacts OCA intake, 1-800-522-8014, during business hours, and after hours calls the Abuse Hotline, 1-800-522-3511.~~

(h~~e~~) **Failure to report abuse, neglect, or exploitation of a child or vulnerable adult.** Any person who knowingly and willfully fails to promptly report ~~a reportable incident as provided for in this Section~~abuse, neglect, or exploitation as required by the provisions of 10A O.S. § 1-2-101 and 43A O.S. § 10-104 may be subject to administrative action or criminal sanctions~~. 43A O.S. § 10-104(E) and 10A O.S. § 1-2-101(C) makes failure to report a misdemeanor,~~ upon conviction. In addition, failure to report by an OKDHS employee may result in disciplinary action.

(i)~~(d)~~**False ~~reporting~~report of abuse, neglect, or exploitation of a child or vulnerable adult.**

(1) ~~Any~~Per 10A O.S. § 1-2-101, any person who knowingly and willfully makes a false report regarding alleged maltreatment of a child, or a report that the person knows lacks factual foundation, may be reported by OKDHS to local law enforcement for criminal investigation and, upon conviction, is guilty of a misdemeanor.

(2) ~~With regard to vulnerable adults~~Per 43A O.S. § 10-104, any person who willfully or recklessly makes a false report of abuse, neglect, or exploitation of a vulnerable adult may be liable in a civil action for any actual damages suffered by the ~~person(s)being~~person reported and for any punitive damages set by the court or jury.

(e~~j~~) **Method of reporting.**

(1) ~~Any person obligated to report an allegation of suspected abuse, neglect, verbal abuse, or exploitation of an OCA client, or caretaker misconduct towards an OCA client, contacts OCA intake in Oklahoma City by telephone at 1-405-525-4850 or 1-800-522-8014, between 8:00 a.m. and 5:00 p.m. on normal business days. At all other times, the Abuse Hotline, 1-800-522-3511 accepts referrals on behalf of OCA. Referrals also are made by completing Form 15GN001E, Office of Client Advocacy Intake Referral, and transmitting it by fax 1-405-525-4885, to OCA, Attn: OCA intake, or sending the same information in an email addressed to oca.advocategeneral@okdhs.org.~~Each report alleging abuse or neglect of a child is screened by the OKDHS Abuse and Neglect Hotline (Hotline) in compliance with Child Welfare Services policies and procedures. Each accepted report of a child within OCA investigative authority and scope is assigned to OCA. Reports may be phoned to the Hotline at 1-800-522-3511, faxed to 405-936-0922, emailed to STO.Hotline.Referral@OKDHS.org, or mailed to Child Abuse and Neglect Hotline, OKDHS, PO Box 25352, Oklahoma City, Oklahoma 73125-0352.

(2) ~~Allegations of exploitation of residents of SORC, NORCE, and Greer are reported to the person designated by the facility administrator to receive and investigate reports of those allegations.~~Reports of abuse, neglect, or exploitation of a Hissom Class Member, resident of SORC, NORCE, or Greer, or other vulnerable adults receiving Developmental Disabilities Services Division services are reported to OCA except for weekends and after business hours when the reports are made to the Hotline at 1-800-

522-3511. Reports to OCA may be phoned to 1-800-522-8014 or 405-525-4850, faxed to 405-525-4885, or emailed to oca.intake@okdhs.org.

(3) ~~In lieu of contacting OCA intake, employees of SORC, NORCE, and Greer also have the option of contacting the quality assurance staff at those facilities. In this event, the reporting staff also notifies the OCA facility advocate staff assigned to the facility. OCA employees and facility staff who receive information about a reportable incident promptly contact OCA intake to transmit that information.~~Reports of abuse, neglect, verbal abuse, financial neglect, or exploitation of a vulnerable adult, receiving services from a Medicaid personal care services provider are reported to the Adult Protective Services office, except for weekends and after business hours when the reports are made to the Hotline at 1-800-522-3511.

(4) Reports of allegations may be submitted by completing Form 15GN001E, Office of Client Advocacy-Intake Referral, and sent to the applicable intake unit.

(~~f~~k) **Confidentiality of reporting party's identity.** ~~OCA keeps confidential the~~The identity of ~~a~~the person who reports ~~an incident involving an incident involving a vulnerable adult per 43A O.S. § 10-105(C)(2), a child or youth per 10A O.S. § 1-6-102(H)(7)~~abuse or neglect of a child or youth per 10A O.S. § 1-6-102(H)(7), or abuse, neglect, or exploitation of a vulnerable adult per 43A O.S. § 10-105.1(C)(2), is kept confidential and not disclosed. ~~OCA accepts anonymous referrals~~ Anonymous reports of abuse, neglect, or exploitation of a child or vulnerable adult are accepted by OKDHS.

~~(g) **Retaliation prohibited.** 43A O.S. § 10-104(K) states that an employer shall not terminate the employment, prevent or impair the practice or occupation of or impose any other sanction on any employee solely for the reason that the employee made or caused to be made a report or cooperated with an investigation pursuant to the Protective Services for Vulnerable Adults Act, 43A O.S. § 10-101 et seq.~~

(~~h~~l) **Staff training regarding reporting obligations.** ~~All administrators ensure theiremployees receive~~Each administrator ensures the employee receives relevant training regarding ~~their reporting responsibilities detailed in this Section~~the employee's responsibility to report a child or vulnerable adult's alleged abuse, neglect, or exploitation. Except for employees of a Developmental Disabilities Services Division (DDSD) provider, ~~employees receive this~~the employee receives the training within 30 calendar days of the employee's initial employment and subsequent training annually. The training for ~~employees of DDSD providers~~the DDSD provider employee is per OAC 340:100-3-38 et seq.

**340:2-3-34. Administrator's responsibilities regarding allegations reportable to Office of Client Advocacy (OCA)**

(a) **~~Immediate~~Facility administrator's responsibility for client's protection,~~for~~ safety, health, and welfare.** ~~If the Office of Client Advocacy (OCA) intake receives an allegation of caretaker maltreatment involving an OCA client from anyone other than the administrator, or the administrator's designee, of the facility or provider responsible for the client, OCA intake promptly notifies the applicable administrator of the allegation.~~When OCA intake receives an allegation of maltreatment by a vulnerable adult caretaker (VAC), from anyone other than the administrator or the administrator's designee, of the facility or provider responsible for the client, OCA intake promptly notifies the applicable administrator of the allegation.

(1) Upon becoming aware of an allegation of caretaker maltreatment involving an Office of Client Advocacy (OCA) client, an administrator ensures the safety, protection, and needed medical attention of any client named in the allegation and other clients receiving services from the facility or provider.

(2) When criminal activity is alleged, the administrator immediately notifies the appropriate local law enforcement authority. The types of criminal activity ~~that are~~ reported to law enforcement include, but are not limited to, the use or possession of illegal drugs, domestic abuse, illegal sexual activity, illegal use of alcohol, theft of money, property, or ~~medicine~~ medication that is a controlled substance, and when someone other than a caretaker is believed to have committed the allegation.

(3) The administrator takes necessary personnel actions to ensure the protection and safety of the alleged victim(s) and other clients. OCA does not determine or approve personnel actions taken by an administrator in response to allegations reported to OCA.

(4) In the event of alleged abuse or neglect of a Hissom class member by a provider's employee or subcontractor, the administrator ensures the protection and medical attention for any class member named in an allegation or other individual served. In the event of alleged abuse or neglect by an individual serving as a provider, it is the responsibility of the class member's case manager to ensure protection, medical attention, or both for the class member. OCA intake notifies the applicable Developmental Disabilities Services Division (DDSD) area manager by ~~e-mail~~email within one working day of receipt of a referral of abuse or neglect by an individual serving as provider for the class member.

(b) **Preliminary assessment.** Upon learning of an incident reportable to ~~OCA~~OKDHS, the administrator:

(1) immediately ensures the safety of any client(s) named in the referral ~~and of other clients~~;

(2) secures any physical evidence and gathers documents within the possession, custody, or control of the facility or provider~~, custody, or control~~ that may be relevant to the allegation;

(3) immediately ~~takes~~ photographs ~~of any~~ injuries. Photographs are taken by ~~someone who was not involved~~a person uninvolved in the incident that is the subject of the allegation relating to the injuries; and

(4) coordinates activities with OCA and ~~any~~ other agency or law enforcement ~~authority~~ authorities involved in investigating the referral.

(c) **Collecting pertinent reports and documents.** The administrator determines which employees were present when the alleged incident occurred and requires each employee to

submit a written account of the alleged incident. The administrator collects medical records, ~~other~~ documents~~,and~~ reports, and other documentary evidence that ~~pertain~~ pertains to the alleged incident, ~~written statements, and other documentary evidence~~ within ~~the possession of~~ the facility or ~~provider~~ provider's, possession, custody, or control and places them in a holding file for OCA investigative use ~~by OCA~~ and ~~any~~ other investigative ~~authority~~authorities. The administrator securely maintains ~~any~~ documents collected during the preliminary assessment.

(d) **OCA access to documents and evidence.** Upon request, an OCA investigator is provided a copy of and access to the original ~~of~~ written statements, incident reports, relevant documents~~,and~~ records, ~~and other~~ reports, photos, and other evidence collected during the preliminary assessment.

(e) **Prohibition from interviewing during preliminary assessment.** ~~Employees of the facility~~ Facility or provider employees do not conduct an investigation of an alleged incident pending the OCA decision to accept the referral for investigation or during a pending OCA investigation. To avoid the consequences of over-interviewing parties involved in an alleged incident, the preliminary assessment is limited to inquiries ~~about who were~~regarding those involved, obtaining written statements, and clarifying information needed to take appropriate action to ensure client safety. Determining if a staff member engaged in maltreatment is not the goal of a preliminary assessment and is avoided until the OCA disposition is determined. This prohibition does not extend to interviews and investigations conducted by law enforcement when responding to a report of criminal activity. The assigned OCA investigator coordinates activities with local, state, and federal law enforcement entities to seek the most appropriate investigative response to the referral.

(f) **Facility and provider contact person.** Each ~~administrator of a~~ facility or provider administrator is responsible for the care of any of the individuals listed in OAC 340:2-3-32(a)(2) and designates a contact person ~~to receive the notice described in subsection (a) of this Section~~. The administrator informs the advocate general of the name, phone number, and ~~e-mail~~email address of the designated contact person~~,~~ and immediately notifies the advocate general in writing, by mail or ~~e-mail~~email, of ~~any~~ changes ~~in this~~ to the information. The designated contact person is ~~reasonably~~ available by telephone, pager, or ~~e-mail between 8:00 a.m. and 5:00 p.m. weekdays, except holidays~~email at all times. Form 15IV011E, Designation of Contact Person for Client ~~Maltreatment~~ Investigations, may be used for this purpose.

(g) **Documentation provided by SORC, NORCE, and Greer.** Within one business day of the Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Robert M. Greer Center (Greer) submitting to the Oklahoma State Department of Health ~~(OSDH)~~ an incident report, a five-day report, or a final report regarding an allegation reported to OCA intake, the facility sends ~~to~~ OCA intake a copy by fax or ~~e-mail~~email attachment.

(h) **Ensuring confidentiality.** Administrators maintain information, files, and documents regarding referrals made to OCA intake, including OCA investigation reports distributed ~~pursuant to~~per OAC 340:2-3-36, in a manner that protects ~~the~~information confidentiality ~~of information contained in them~~.

*[OAR Docket #13-892; filed 5-22-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 2. ADMINISTRATIVE COMPONENTS

*[OAR Docket #13-886]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 31. ~~Legislative~~Intergovernmental Relations and Policy
Part 4. Office of ~~Legislative~~Intergovernmental Relations and Policy
340:2-31-10 [AMENDED]
Part 5. Petitioning for Rulemaking
340:2-31-31 through 340:2-31-33 [AMENDED]
Subchapter 33. Rates and Standards
340:2-33-1 through 340:2-33-3 [AMENDED]
**(Reference WF12 23)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes (56 O.S. § 162); Administrative Procedures Act, 75 O.S. §§ 250 et. seq.; the Oklahoma Central Purchasing Act, 75 O.S. §§ 85.1 et. seq.; and Article XXV, Sections 2 and 4 of the Oklahoma Constitution repealed November 6, 2012.
**DATES:**
**Comment period:**
January 15, 2013 through February 14, 2013
**Public hearing:**
None requested
**Adoption:**
March 18, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
**SUMMARY:**
The proposed revisions to Subchapters 31 and 33 of Chapter 2 amend rules to: (1) comply with Constitution and Statute changes; (2) revise sentence structure; and (3) update language and division name.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED**

**FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 31. ~~LEGISLATIVE~~INTERGOVERNMENTAL RELATIONS AND POLICY

## PART 4. ~~OFFICE OFLEGISLATIVE~~INTERGOVERNMENTAL RELATIONS AND POLICY

### 340:2-31-10. ~~Legislative~~Intergovernmental relations and policy

(a) **Purpose.** The Office of ~~Legislative~~Intergovernmental Relations and Policy (~~OLRP~~OIRP):

(1) serves as the liaison between the Oklahoma Department of Human Services (OKDHS) and the state legislature and state agencies;

(2) ~~serves as the liaison to the Oklahoma Health Care Authority (OHCA);~~

~~(3)~~ chairs and staffs the OKDHS Committee on Rates and Standards;

~~(4)~~ ~~provides staff for the Human Services Cabinet;~~

(~~5~~3) manages OKDHS rules, policy, and procedures; and

(~~6~~4) ensures policy and other forms of ~~communications~~communication comply with federal and state statutes.

(b) **Legal authority.** OKDHS rules are promulgated per the Administrative Procedures Act, Sections 250.1 through 323 of Title 75 of the Oklahoma Statutes.

## PART 5. ~~PETITIONING FOR~~ RULEMAKING PETITION

### 340:2-31-31. ~~Petitions for rulemaking~~Rulemaking petition

(a) **Submission.** Any person may petition the Oklahoma Department of Human Services (OKDHS) in writing to request the promulgation, amendment, or repeal of a rule.

(1) The ~~petition for rulemaking~~rulemaking petition is submitted to the OKDHS Office of ~~Legislative~~Intergovernmental Relations and Policy (~~OLRP~~OIRP) ~~Policy Management Unit (PMU)~~ by:

(A) mail to ~~P.O.~~PO Box 25352, Oklahoma City, ~~OK~~Oklahoma 73125, Attention, ~~Policy Management Unit~~Office of Intergovernmental Relations and Policy; or

(B) delivery to the Sequoyah Memorial Office Building, 2400 N. Lincoln Blvd., Oklahoma City, ~~OK~~Oklahoma.

(2) The rulemaking petition is considered submitted upon OIRP receipt ~~in OLRP~~.

(A) ~~OLRP~~OIRP date stamps the ~~petition for rulemaking~~rulemaking petition to document receipt date ~~of receipt~~.

(B) A ~~petition for rulemaking~~rulemaking petition submitted to the ~~OKDHS~~ Director of Human Services (Director) is forwarded to~~,~~ and considered submitted,~~when received in OLRP~~upon OIRP receipt.

(b) **Form and content.** The ~~petition for rulemaking~~rulemaking petition must contain:

(1) a clear statement of the requested action ~~requested~~ and the desired relief or solution ~~desired as a result of the requested new rule or rule revision~~;

(2) the Title, Chapter, Subchapter, and Section, if known, or a copy of the existing rule ~~that is~~ proposed ~~to be revised or a copy of the rule~~for revision;

(3) a statement of ~~the facts~~ supporting ~~the requested new rule or rule revision~~facts, including ~~any~~ legal grounds, and other relevant information or views on which the petitioner relies.

(A) A copy of ~~any reference or source~~references or sources cited in the statement ~~is~~ are submitted with the rulemaking petition ~~unless the reference or source is readily available to OKDHS~~.

(B) When a petition requests more than one rule revision, a single statement that supports and justifies each proposed revision meets the requirements of this subsection;

(4) a description of the class or classes of persons, if known, who ~~most likely~~ will most likely be affected by the proposed revision; and

(5) the petitioner or authorized representative's signature,~~and~~ printed name, address, and day time telephone ~~number~~numbers~~of the petitioner or authorized representative~~.

(c) **Incomplete or revised petition.**

(1) When the ~~petition for rulemaking~~rulemaking petition does not contain the~~minimally~~ required information, the petitioner or authorized representative is sent a written request for additional information ~~in writingthat specifies the manner in which~~ specifying how the rulemaking petition is deficient.

(2) The petitioner or authorized representative may supplement or revise the rulemaking petition ~~for rulemaking at any time~~ prior to the Director's approval ~~by the OKDHS Director or submission of the proposed change to the Oklahoma Commission for Human Services. Significant changes~~; however, significant revisions may result in withdrawal of the rulemaking petition and require re-initiation of the rulemaking process with a new rulemaking petition.

### 340:2-31-32. Consideration and disposition of ~~petition for rulemaking~~rulemaking petition

(a) ~~**Review of petition**~~**Rulemaking petition review.** Within 15 calendar days after receipt of a rulemaking petition to promulgate, amend, or repeal a rule, the Office of ~~Legislative~~ Intergovernmental Relations and Policy (~~OLRP~~OIRP) reviews the petition and after consultation with the ~~Oklahoma~~

~~Department of Human Services (OKDHS)~~ Director of Human Services (Director) denies, requests additional information, or initiates rulemaking proceedings.

(b) **~~Denial of petition~~Rulemaking petition denial.** The ~~petition for rulemaking~~rulemaking petition is denied, in whole or in part when the petition:

(1) requests promulgation of a rule that Oklahoma Department of Human Services (OKDHS) is clearly without authority to promulgate;

(2) requests a new rule or rule revision inconsistent with or that violates any applicable statutory or constitutional authority;

(3) requests promulgation, amendment, or repeal of an OKDHS policy that does not constitute a rule as defined in the Oklahoma Administrative Procedures Act ~~at~~per Section 250.3(~~2~~17) of Title 75 of the Oklahoma Statutes;

(4) is frivolous ~~and~~or not proposed in good faith; or

(5) proposes a new or revised rule that is not feasible based on available ~~and~~or anticipated OKDHS resources.

~~(A)~~ When denial is based on feasibility, the ~~OLRP~~OIRP coordinator or designee notifies the petitioner of the denial ~~in accordance with~~per OAC 340:2-31-33. ~~The petitioner may make a written request to the OLRP coordinator to present the petition to the Oklahoma Commission for Human Services (Commission).~~

~~(i) Within five working days of receipt of the request, the OLRP coordinator submits the petition, written recommendations, and all other relevant information to the Chair of the Commission with a copy to the affected division.~~

~~(ii) The Chair of the Commission approves or denies the petitioner's request.~~

~~(I) If the Chair denies the petitioner's request, the OLRP coordinator or designee notifies the petitioner in accordance with OAC 340:2-31-33 and the affected division.~~

~~(II) If the Chair approves the petitioner's request, the petition is placed on theCommission agenda and OLRP notifies the affected division.~~

~~(iii) At the Commission meeting, the petitioner may present arguments in favor of the new rule or rule revision. The OLRP coordinator has the opportunity to present the OKDHS reasons for denial of the petition.~~

~~(iv) The Commission either directs the initiation of rulemaking procedures as requested, in full or in part, or denies the petition. The OLRP coordinator or designee notifies the petitioner in writing of the final Commission decision.~~

(c) **~~Approval of petition~~Rulemaking petition approval.** OKDHS rulemaking proceedings are initiated when ~~OLRP~~OIRP submits the approved ~~petition for rulemaking~~rulemaking petition to the appropriate division director for action.

(1) Within 60 calendar days after ~~receipt of the petition by~~ the affected division receives the rulemaking petition, the division director places the ~~proposed new rule or rule revision~~ proposal into the proper ~~format for proposed~~ rulemaking ~~action~~format, and submits ~~the proposal~~it to ~~OLRP for intra-agency circulation and review~~OIRP.

(2) ~~Intra-agency review is completed and the~~The~~proposed new rule or rule revision~~proposal is submitted to the ~~OKDHS~~ Director within 45 calendar days after ~~initial intra-agency circulation~~ OIRP receipt.

(3) Within 30 calendar days ~~of receiptof the proposed new rule or rule revision by the OKDHS Director~~after the Director's receipt, the ~~OKDHS~~ Director recommends approval, disapproval, or amendment of the ~~proposed rule change~~proposal. ~~When the Director recommends approval, the OLRP coordinator or designee submits the proposal to the Commission for action at the next regularly scheduled Commission meeting for which there has been sufficient time to place the proposal on the Commission agenda.~~

**340:2-31-33. ~~Notification to petitioner~~Rulemaking petitioner notification**

Within five working days of receipt of the ~~petition for rulemaking~~rulemaking petition, the Office of ~~Legislative~~Intergovernmental Relations and Policy (~~OLRP~~OIRP) coordinator or designee provides written notification to the petitioner of the petition receipt ~~of the petition~~. Within five working days after any action taken related to the petition, ~~OLRP~~OIRP provides written notification to the petitioner of:

(1) ~~denial of the~~rulemaking petition denial, in whole or in part, including the reasons for the denial;

(2) initiation of Oklahoma Department of Human Services (OKDHS) rulemaking proceedings, including the ~~date of submission of the~~ proposed rule revision submission date to the ~~OKDHS~~ Director of Human Services (Director) for approval;

(3) the substance of comments received and any revisions made ~~during the intra-agency review period,~~ including a copy of the revised rule proposed by the division; and

(4) any Director action ~~by the OKDHS Director and the Commission for Human Services (Commission)~~ on the proposed rule revision~~; and~~

~~(5) the date, time, and place of the Commission meeting when the proposed rule revision will be considered~~.

## SUBCHAPTER 33. RATES AND STANDARDS

**340:2-33-1. Purpose**

(a) The purpose of this Subchapter is to describe the process ~~that~~ the Oklahoma Department of Human Services (OKDHS) uses for establishing and modifying fixed rates and service levels for service provider contracts.

(b) The ~~Oklahoma Commission for Human Services (Commission) is the official rate-setting body~~ Director of Human Services (Director) sets the rates for ~~the~~OKDHS administered programs ~~administered by OKDHS~~.

(c) The policies and procedures in this Subchapter describe how information and recommendations are collected and provided to the ~~Commission members~~Director for ~~their~~ use in establishing service rates and standards ~~for services~~.

**340:2-33-2. Legal basis and role of the Department of Central Services**

(a) The Oklahoma Central Purchasing Act found at Section 85.1 et. seq. of Title 74 of the Oklahoma Statutes is the legal basis for establishing fixed and uniform rates ~~is the Oklahoma Central Purchasing Act found at Section 85.1 et. seq. of Title 74 of the Oklahoma Statutes~~.

(b) The statute requires ~~that any agency~~agencies desiring to have a service qualified for a fixed and uniform rate, or an established rate modified, submit a written request and all supporting documentation to the ~~Department of Central Services (DCS)~~Office of Management and Enterprise Services Division of Capital Assets Management (DCAM). If ~~DCS~~DCAM qualifies such service for a fixed and uniform rate, the rate must then be approved in a public hearing before ~~a contract can be legally entered into by the agency~~the agency can enter into a legal contract.

(1) The agency notifies the DCAM Director ~~of DCS~~ at least 30 days in advance of the scheduled hearing. ~~Along with the notice the~~The agency delivers the notice, a copy of the agenda items relating to the proposed rate,~~with~~and all supporting documentation.

(2) The DCAM Director ~~of DCS~~ communicates a recommendation to the agency ~~either~~ in advance of the hearing or at the time of the hearing. Whether made in person or in writing, any comment made by the DCAM Director ~~of DCS~~ is, by law, included in the ~~minutes of the~~ hearing minutes.

(c) Within two weeks after the ~~convening of the~~ Legislature convenes, the administrative officer of each state agency ~~furnishes to~~provides the Speaker of the House of Representatives and the President Pro Tempore of the Senate a complete list of all ~~the types of~~ services paid for by uniform fixed rates and the number of contracts in existence for each type of service.

**340:2-33-3. Committee on Rates and Standards**

(a) The Committee on Rates and Standards (Committee) is comprised of Oklahoma Department of Human Services (OKDHS) administrative and executive level staff designated by the ~~OKDHS~~ Director of Human Services (Director).

(b) The ~~Oklahoma Commission for Human Services (Commission) is the official rate setting body for~~Director sets OKDHS rates.

(c) The Committee serves the rate setting process by conducting public hearings ~~at which~~where the public, vendors, and OKDHS staff are afforded the opportunity to provide testimony and documented evidence in support of rate recommendations.

(1) The Committee, by majority vote, records a recommendation to the ~~Commission~~Director setting forth specific payment rates ~~of payment~~ for specific services. If the Committee determines additional information is needed, the chair may recess the meeting until a later date to allow interested parties or staff additional time to secure the information.

(2) Once the Committee reaches a recommendation, the ~~chair schedules the rate issue to be heard at the next scheduled Commission meeting~~Director reviews and approves or disapproves the rate.

~~(3) At the Commission meeting, the Committee chair presents the rate issue and relays the Committee's recommendation to the Commission.~~

~~(4) After the presentation and after hearing further public testimony, if appropriate or requested, the Commission votes to approve, deny, or modify the recommendation of the Committee.~~

*[OAR Docket #13-886; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

*[OAR Docket #13-888]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Conditions of Eligibility - Need
Part 5. Assistance Payments
340:10-3-57 [AMENDED]
Subchapter 4. Mandatory Drug Screening [NEW]
340:10-4-1 [NEW]
**(Reference APA WF 12-20)**
**AUTHORITY:**
Director of Human Services; 56 O.S. §162 and §230.52 and HB 2388 effective November 1, 2012.
**DATES:**
**Comment period:**
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**Public hearing:**
None requested
**Adoption:**
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**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
**Superseded rules:**
Subchapter 3. Conditions of Eligibility - Need
Part 5. Assistance Payments
340:10-3-57 [AMENDED]
Subchapter 4. Mandatory Drug Screening [NEW]
340:10-4-1 [NEW]
**(Reference APA WF 12-20)**
**Gubernatorial approval:**
December 5, 2012

**Register publication:**
30 Ok Reg 338
**Docket number:**
13-150
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed revisions to Subchapter 3 of Chapter 10 amend the rules per 56 O.S. § 230.52 and HB 2388 to: (1) explain how the income is counted in determining eligibility for child only TANF benefits when adult parents or needy caretakers are not included in the TANF benefits due to a positive drug screen for use of an illegal controlled substance or substances; and (2) define the term "living in the home with" when used regarding a person acting in the role of spouse.

Subchapter 4 of Chapter 10 is created to comply with 56 O.S. § 230.52 and HB 2388 to: (1) mandate drug screening for adult parents or needy caretakers that apply for or receive TANF cash assistance; (2) describe reasonable cause indicators of illegal use of controlled substance or substances; (3) describe screening methods; and (4) describe procedures to follow when the adult refuses to comply or fails to follow through with screening, or complies and screens positive for the use of an illegal controlled substance or substances.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. CONDITIONS OF ELIGIBILITY - NEED

## PART 5. ASSISTANCE PAYMENTS

### 340:10-3-57. Special considerations

(a) **Concurrent receipt of State Supplemental Payment (SSP) for the aged, blind, or disabled.** A person who is not a recipient of Supplemental Security Income (SSI) has an option to be included in a Temporary Assistance for Needy Families (TANF) assistance unit or may be a recipient of SSP if all eligibility requirements are met. The person may also be included in the TANF assistance unit pending determination of eligibility for SSP or SSI if all eligibility requirements are met.

(b) **Concurrent receipt of TANF and SSI.** A person is not included in a TANF benefit for the same month he or she is included in an SSI payment. ~~If it appears~~When a person included in a TANF application or an active TANF benefit meets the eligibility conditions for TANF and SSI, the person has a choice to have eligibility determined for TANF or SSI benefits. The worker informs the payee of his or her responsibility to report to the Oklahoma Department of Human Services (OKDHS) if any member of the assistance unit makes application for SSI or becomes eligible for SSI. If any assistance unit member applies for TANF, or is receiving TANF when the member makes an application for SSI~~,~~ the payee must inform the Social Security Administration (SSA).

(1) When the only dependent child(ren) is receiving SSI, the natural or adoptive parent(s) or needy caretaker relative may receive TANF if all other eligibility factors ~~of eligibility~~ are met. The assistance unit consists of the adult(s) only.

(2) When a TANF applicant is also ~~an~~a SSI applicant ~~for SSI~~, TANF eligibility ~~for TANF~~ must be determined and, if eligible, is included in the benefit until notified of SSI eligibility.

(3) When a TANF recipient is ~~an~~a SSI applicant ~~for SSI~~, SSA advises OKDHS of SSI eligibility, and requests the month of TANF termination and the amount of TANF benefits paid for each month of SSI eligibility. SSA considers a recipient removed from a TANF benefit effective with, and based on, the TANF termination date provided orally by the worker. If the actual date of termination is later than the date given orally to SSA, TANF payments to SSI recipients are TANF overpayments and must be recouped.

(4) When a TANF recipient is determined ineligible for SSI the person may continue to be included in the TANF assistance unit if all other conditions of eligibility are met.

(5) When a TANF recipient is determined ineligible for SSI for reasons other than a disability determination, the person may be included in an SSP, if all other eligibility conditions ~~of eligibility~~ are met.

(c) **Concurrent receipt of state and tribal TANF.** A person included in a tribal TANF payment is not included in another TANF benefit in the same month. If the person meets the criteria of a tribal TANF service area and population, the entire assistance unit must be served by tribal TANF. If the household moves out of the tribe's service area, the worker coordinates certification of state TANF benefits.

(d) **Concurrent receipt of more than one form of public assistance.** A person included in a TANF benefit is not included in another TANF or SSP benefit for the same period. When a TANF applicant is eligible for TANF but has received a weekly or bi-monthly TANF benefit from another state for the same month the applicant is eligible in Oklahoma, the benefit from the other state is counted as unearned income. A person who is the payee for a TANF benefit, but not included in that benefit, is not prevented from being a SSP recipient ~~of SSP~~ if the SSP eligibility requirements are met. When transferring a TANF recipient to SSP, the removal and approval date must agree.

(e) **Stepparent, spouse of needy caretaker, person acting in the role of a spouse, parent who is ineligible as a result of a positive screen for the illegal use of a controlled substance or substances, or parent(s) of a minor parent.** The natural or adoptive parent's income cannot be diverted to meet the needs of the stepparent or other dependents in the home, but is considered available to the TANF assistance unit. No income is considered if the stepparent, spouse of a needy caretaker, person acting in the role of a spouse, parent(s) of a minor parent, or his or her dependent is an SSI recipient.

(1) **Stepparent or spouse of needy caretaker income.** If a stepparent of the child(ren) or the spouse of a needy caretaker for whom TANF is requested lives in the home with the child(ren), the worker computes the verified gross earned and unearned income of the stepparent or spouse of a needy caretaker, after all applicable TANF income

disregards and work related expenses, to determine the amount considered available to the assistance unit. The worker computes the stepparent's or spouse of a needy caretaker's income by:

(A) subtracting the work related expense, one-half of the remaining gross earned income, and dependent care expense from the stepparent's or spouse of a needy caretaker's earned income for full-time or part-time employment; [OAC 340:10-3-33]

(B) adding the net earned income to the stepparent's or spouse of a needy caretaker's gross unearned income;

(C) subtracting the need standard for the appropriate number of persons, including the stepparent or spouse of a needy caretaker and dependents who are not included in the assistance unit but are living in the home and can be claimed on the stepparent's or spouse of a needy caretaker's personal income taxes;

(D) subtracting the actual amounts the stepparent or spouse of a needy caretaker paid to persons not living in the household but claimed as tax dependents. It is the stepparent's or spouse of a needy caretaker's responsibility to identify and verify tax dependents;

(E) subtracting the actual payments of alimony and child support to persons outside the household; and

(F) adding the stepparent's or spouse of a needy caretaker's remaining net income to all other gross income of persons included in the TANF assistance unit. If the income does not exceed the monthly maximum gross income, the remaining income of the stepparent or spouse of a needy caretaker is considered as a contribution to the assistance unit.

(2) **Stepparent or spouse of a needy caretaker resources.** The worker does not consider resources owned exclusively by the stepparent or spouse of a needy caretaker to determine the assistance unit's resource eligibility but does consider the assistance unit's share of resources owned jointly with the stepparent or spouse of a needy caretaker.

(3) **Person acting in the role of a spouse.** The worker must count the income of a person acting in the role of a spouse who lives in the home with the natural or adoptive parent when he or she does not receive a TANF benefit on another case.

(A) For the purpose of this rule, "living in the home with" means that a person of the opposite sex is acting in the role of a spouse.

(i) The opposite sex individual is acting in the role of a spouse when one or both of these factors exist:

(I) they represent themselves to be a couple; or

(II) have a physical relationship with each other.

(ii) When the client states the conditions in (A)(i) of this paragraph do not exist, factors that may indicate the opposite sex individual is acting in the role of a spouse include when he or she:

(I) assists in parenting the child, such as exercising responsibility for the child(ren), providing day-to-day care, physical care, and guidance for the child(ren);

(II) provides financial support for the family beyond his or her own pro rata share of the household expenses;

(III) shares joint bank accounts or real property ownership with the client; or

(IV) files a joint tax return with the client.

(B) The worker computes the income of this person the same as stepparent income. The person acting in the role of spouse is not eligible to receive the exemption of one-half of the remainder or a dependent care expense deduction in determining this person's countable earned income.

(C) If the parent or the person acting in the role of a spouse fails to provide information necessary to determine income eligibility, the application is denied or the cash assistance terminated. Provided~~,~~ however, the income of non-relative adults of the opposite sex not receiving TANF may be excluded if the adults have separate living quarters and demonstrate no characteristics of a person acting in the role of spouse.

(4) **Parent who is ineligible as a result of a positive screen for the illegal use of a controlled substance or substances.** The income, earned and unearned, of a parent who is ineligible as a result of a positive screen for the illegal use of a controlled substance or substances per OAC 340:10-4-1 is considered in its entirety.

(~~4~~5) **Parent(s) of a minor parent.** When a minor parent is living in the home with his or her natural or adoptive parent(s) and the needs of the parent(s) are not included in the assistance unit, the parent's income is considered available to the assistance unit and computed the same as stepparent income. The income of a minor parent's stepparent is not considered. The parent of the minor parent may be designated as the substitute payee for the assistance unit.

(f) **Allocating or diverting income.** When family members are not included in the assistance unit, special consideration is required in determining the income available to the assistance unit.

(1) Income received by a person included in the assistance unit is not allocated or diverted to persons who are not in the assistance unit. All countable unearned and earned income of the person is considered available to the assistance unit.

(2) The net income of an alien parent excluded from the benefit because the citizenship or alienage requirement is not met is considered the same as stepparent income. The needs and income of disqualified alien siblings are not considered when determining eligibility of an otherwise eligible child(ren).

(3) The net income of a fugitive felon excluded from the benefit is considered the same as stepparent income.

(g) **Benefit reduction as a result of program violation.** The TANF benefit is reduced by 25% of the payment standard when a determination of program violation ~~has been~~is made.

The 25% penalty is removed the next effective date when compliance is documented or the penalty time ~~frame for the penalty has ended~~period ends. When multiple types of program violations have occurred, a 25% for penalty of the payment standard is imposed for each type of violation. If the benefit reduction causes existing income to be in excess of the benefit amount, the case is closed using the reason for the benefit reduction. The amount of the payment standard reduction applies as Food Stamp Penalty Income in the Supplemental Nutrition Assistance Program (SNAP) per OAC 340:50-7-29(c)(1)(A). Reasons for benefit reduction are:

(1) refusal to cooperate in an effort to obtain child support per OAC 340:10-10-5(c);

(2) failure to apply for or provide a Social Security number per OAC 340:10-12-1;

(3) failure of a child(ren) kindergarten to 18 years of age to attend school per OAC 340:10-13-1;

(4) failure to provide verification of child(ren) immunizations per OAC 340:10-14-1; and

(5) intentional program violations determined as fraud by court action or an administrative disqualification hearing or administrative hearing waiver per OAC 65-9-2(d) and OAC 340:65-9-4(c)(1)(A-C).

(h) **Parent living in the home receiving SSP.** When there is a parent living in the home but not included in the TANF benefit because of receipt of SSP and not SSI, no consideration is ~~not~~ given to that parent's individual income for the TANF benefit. When a parent in the SSP benefit becomes ineligible to continue to receive the SSP, the parent is included in the TANF benefit and all the income and resources of the parent are considered in determining eligibility for TANF. If consideration of the parent's income and resources causes the TANF benefit to be closed, and the closure of the SSP benefit was a direct result of an overall Social Security increase, the SSP benefit is placed in Special Medical Status. If the parent is living in the home but not included in the TANF benefit because of receipt of SSP and SSI, no consideration is given to the parent's income and the parent is not included in the TANF assistance unit as long as the parent remains eligible for SSI.

(i) **TANF eligibility when the child(ren) is placed in out-of-home care.** When the child(ren) is removed by a child protection action and it is reasonably anticipated the child(ren) will return to the home within four months, the natural or adoptive parent or needy caretaker relative continues eligible for TANF, if other conditions of eligibility are met.

(1) A team consisting of the worker, ~~the~~ Child Welfare (CW) worker, ~~the~~ natural or adoptive parent or needy caretaker relative, and any other appropriate partner(s) must meet to develop a mutually agreed upon plan of action. This plan addresses employability and strategies to correct the conditions ~~which~~that caused the child(ren) to be removed from the home.

(2) At the end of the four month period if the child(ren) has not been returned to the home, the adult(s)' needs are removed and the TANF benefits are discontinued.

(j) **Strikers.** The assistance unit is not eligible for TANF for any month the natural or adoptive parent, whether ~~or not~~ included in the benefit, is participating in a strike on the last day of that month. A person other than the natural or adoptive parent is not included in the benefit for any month if that person is participating in a strike on the last day of the month.

## SUBCHAPTER 4. CONDITIONS OF ELIGIBILITY - MANDATORY DRUG SCREENING

### 340:10-4-1. Mandatory Drug Screening

(a) Per Section 230.52 of Title 56 of the Oklahoma Statues, adult parents, or needy caretakers who apply for Temporary Assistance for Needy Families (TANF) cash assistance are required to be screened for illegal use of a controlled substance or substances. TANF child only cases and minor parents under the age of 18 are exempt from the provisions in this Section.

(b) At any point the Oklahoma Department of Human Services (OKDHS) has reasonable cause to believe the adult parent or needy caretaker currently receiving TANF cash assistance is engaged in the illegal use of a controlled substance or substances, the adult parent or needy caretaker is required to be screened. OKDHS is authorized to request administration of a chemical drug screen, such as an observed urinalysis (UA). Behaviors observed by OKDHS staff or observed and reported by community resource partners that might indicate illegal use of a controlled substance or substances include, but are not limited to:

(1) slurred speech;

(2) unsteady gait;

(3) inability to focus;

(4) lethargy;

(5) excessive nervousness or agitation;

(6) showing flat affect or no emotion;

(7) inappropriate responses to questions;

(8) inappropriate anger or hostility;

(9) excessive worry;

(10) facial tics or muscle spasms;

(11) erratic attendance in TANF Work activities;

(12) lack of follow through with agreed upon plans; or

(13) government or law enforcement documents indicating the person was engaged in the illegal possession or use of a controlled substance or substances within the last 30 calendar days.

(c) The minimum drug screening includes a Substance Abuse Subtle Screening Inventory (SASSI). Additional screening methods may be used that include, but are not limited to a clinical interview, consideration of the person's history with OKDHS, and an Addictions Severity Index (ASI). Additional screening and UA must be completed when the results of the initial SASSI screening are high probability, invalid, or the client self-declares a substance abuse problem.

(d) The TANF application is approved with the adult parent or needy caretaker's needs included when all other factors of eligibility are met and the substance abuse:

(1) screening result indicates low probability of illegal use of controlled substance or substances; or

(2) assessment result is a recommendation for alcohol and/or prescription drug abuse treatment.

(e) The TANF application is denied or benefits are closed if the adult parent or needy caretaker refuses to comply or fails to follow through with the screening.

(f) When the adult parent or needy caretaker applicant screens positive for the illegal use of a controlled substance or substances,the worker denies the TANF application or closes the TANF benefit for the adult parent or needy caretaker. The parent or needy caretaker may choose to receive child only benefits if all other factors of TANF eligibility are met. If the choice is to receive child only benefits, the worker approves or continues child only benefits using the current TANF application. The worker also:

(1) provides the denied applicant or adult recipient with a list of substance abuse treatment programs available at minimal or no cost to the applicant or recipient;

(2) makes a referral to the Child Abuse Hotline at 1-800-522-3511 of the positive screen for illegal drug use;and

(3) determines eligibility of all household members for other requested program benefits.

(g) If the adult parent or needy caretaker is ineligible as a result of a positive screen for illegal use of a controlled substance or substances, he or she is not eligible for TANF benefits until:

(1) one year has passed since the date of the first ineligibility determination;

(2) six months have passed since the date of the first ineligibility determination and the adult parent or needy caretaker has complied with a substance abuse treatment plan; or

(3) three years have passed since the date of the second or subsequent ineligibility determination.

(h) At the end of an ineligibility period, a new application is required and all factors of eligibility determined. The steps described at (a) and (c) through (f) are followed.

*[OAR Docket #13-888; filed 5-22-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 25. OKLAHOMA CHILD SUPPORT SERVICES

*[OAR Docket #13-893]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Operational Policies
Part 21. Establishment.
340:25-5-179.1 [AMENDED]
**(Reference WF 12-12)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes (56 O.S. § 162); Social Security Act (SSA), codified at Chapter 7 of Title 42 of the United States Code (42 U.S.C. §§ 301- 1397mm); Child Support Performance and Incentive Act of 1998, Public Law (Pub. L.)105-200; 42 U.S.C. § 653-654; 42 U.S.C. § 608; 50A U.S.C. §§ 501-596; Section 264.30 of Title 45 of the Code of Federal Regulations (45 C.F.R. § 264.30); 45 C.F.R. §§ 302.32-302.33; 56 O.S. § 238.6B; 56 O.S. § 238.1; 43 O.S. §§ 118-119; 10 O.S. §§ 83 and 7700-636.

**DATES:**
**Comment period:**
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**Public hearing:**
None requested
**Adoption:**
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**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
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July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed amendments to Chapter 25 Subchapter 5 amends the rule to: (1) implement policy changes recommended during the annual Oklahoma Child Support Services (OCSS) policy review process; and (2) make non-substantive housekeeping changes to improve rule clarity.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 5. OPERATIONAL POLICIES

### PART 21. ESTABLISHMENT

**340:25-5-179.1. Establishment of support for a prior period**

(a) Oklahoma Child Support Services (OCSS) establishes support for a prior period.

(1) When paternity is being established by court order or when paternity has been previously established by a signed Form 03PA209E, Acknowledgment of Paternity, OCSS establishes current support and support for a prior period at the same time per Sections 83 and 7700-636 of Title 10 (10 O.S. §§ 83 and 7700-636), ~~Sections 118 and 119 of Title 43~~43 O.S. §§ 118-118I and 119, and ~~Section 238.6B of Title 56 of the Oklahoma Statutes~~56 O.S. § 238.6B.

(2) When a child(ren) is born during a marriage and no order addressing support for a prior period exists, OCSS establishes support for a prior period per ~~Sections 118 and 119 of Title 43 and Section 238.1 of Title 56 of the~~

~~Oklahoma Statutes~~43 O.S. §§ 118-118I and 119 and 56 O.S. § 238.1.

(A) OCSS establishes support for a prior period under this subsection only when:

(i) current child support is sought; and

(ii) Temporary Assistance for Needy Families (TANF) or Title IV-E and non-Title IV-E eligible foster care has been expended in any month during the past five years per OAC 340:75-13-26.

(B) OCSS may issue a Notice of Support Debt or file a district court action to establish support for a prior period. OCSS limits this prior period to the number of months on TANF or Title IV-E and non-Title IV-E eligible foster care during the five years immediately before the date OCSS issues the Notice of Support Debt, or files the district court action.

(b) When a child support order is entered against a minor noncustodial parent (NCP), OCSS establishes support for a prior period under the criteria for establishing current child support per OAC 340:25-5-178. ~~OCSS establishes a monthly payment plan amount of at least $1 a month.~~

(c) OCSS does not establish an order for support for a prior period on an incarcerated ~~noncustodial parent~~NCP. OCSS requests the court reserve the amount of child support for the ~~time~~ period prior to the entry of the court order through the time of incarceration to the date the current child support obligation begins per OAC 340:25-5-178.

(d) When OCSS establishes an order for support for a prior period for a child of a ~~noncustodial parent~~NCP or a custodial person who is a servicemember, OCSS applies the provisions of the Servicemembers Civil Relief Act, codified in Sections 501 through 596 of Title 50A of the United States Code.

(e) When the ~~noncustodial parent~~NCP is a current TANF or Supplemental Security Income (SSI) recipient and OCSS:

(1) has information that the ~~noncustodial parent~~NCP had no obligation based on the child support guidelines for the prior ~~time~~ period, OCSS requests the court set the judgment at $0; or

(2) determines ~~that~~ a debt may be owed for a prior period, OCSS requests the court reserve the issue of support for a prior period until the ~~noncustodial parent~~NCP is no longer receiving TANF or SSI.

(f) OCSS sets a monthly payment schedule per OAC 340:25-5-140.

*[OAR Docket #13-893; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 40. CHILD CARE SUBSIDY PROGRAM

*[OAR Docket #13-889]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 7. Eligibility
340:40-7-6 [AMENDED]
340:40-7-11 [AMENDED]
**(Reference APA WF 12-13)**
**AUTHORITY:**
Director of Human Services;Section 162 of Title 56 of the Oklahoma Statutes; and Title 45 of the Code of Federal Regulations (CFR) Parts 98 and 99.
**DATES:**
**Comment period:**
January 2, 2013 through February 1, 2013
**Public hearing:**
None requested
**Adoption:**
March 18, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed revisions to Subchapter 7 of Chapter 40 amend the rules to: (1) clarify who must meet a need factor and apply for benefits when someone is temporarily absent from the home; and (3) update terminology.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 7. ELIGIBILITY

**340:40-7-6. Household composition and income consideration**

(a) **Definition of household composition terms.** The worker determines household composition for income considerations using the definition of terms listed in (1) through (9) of this subsection.

(1) An adult is an emancipated minor or person 18 years of age or older. A child who is also a parent is considered an adult.

(2) A spouse is a person married by ceremony or common-law to another person. They can be living together or separately. If they are living separately, they are considered part of the household if the separation is temporary with no intention of severing the marital relationship or the separation is involuntary.

(3) A stepparent is a person who is a spouse or has been a spouse to the child's parent.

(4) A caretaker is an adult ~~that~~ the child is living with who is acting in the role of a parent. This person may or may not be related to the child by blood, adoption, or marriage and may or may not be legally and financially responsible for the child. The caretaker must pursue child support from the natural or adoptive parent per OAC 340:40-7-9.

(5) An adult non-relative is defined as any person over 18 years of age or an emancipated minor who is not related to the parent or caretaker by blood, adoption, or marriage.

(6) The term legally and financially responsible adult is defined as a parent or stepparent of the child who needs child care. The term also includes other caretaker adults who are court-ordered to be legally and financially responsible for the child.

(7) A child is any unmarried, unemancipated, non-parental person under 18 years of age.

(8) A child who has married or voluntarily left the parental home for any reason and established independent living arrangements, other than being away from home for school or health reasons, is considered emancipated and treated as an adult. Once a child is emancipated, the emancipation is permanent.

(9) A sibling is a minor child who has at least one parent in common with another child in the same household. This definition of a sibling also includes a step-brother or step-sister.

(b) **Household composition and income consideration.** To establish a child's eligibility for subsidized child care benefits, it is necessary to define who must be considered part of household composition for income consideration. All persons whose income is counted in determining the family share co-payment are included to determine whether to use a family size of five members or less or for six or more members on OKDHS Appendix C-4, Child Care Eligibility/Co-payment Chart. Persons whose income must be considered in determining eligibility are:

(1) the natural, adoptive, or stepparent of the child living in the home who needs child care;

(2) the caretaker(s) of the minor child needing child care if that caretaker is legally and financially responsible for the child;

(3) the child needing child care and his or her siblings under 18 years of age living in the home;

(4) any adult non-relative opposite sex individual (ANROSI) who is living in the home with the natural or adoptive parent provided, however, the income of the non-relative adult of the opposite sex may be excluded if the parent and the adult non-relative have separate living quarters and demonstrate no characteristics of a couple; and (5) any child of the ANROSI who is living in the home with the natural or adoptive parent.

(c) **Periods of absence.**

(1) When a household member is out of the home due to a temporary absence, he or she is considered a household member as long as he or she plans to return to the home. Any parent or caretaker(s) who remains in the home must meet a need factor per OAC 340:40-7-8. Examples of temporary absence include, but are not limited to:

(A) hospitalization for physical or mental health reasons;

(B) incarceration;

(C) attending school;

(D) military service;

(E) working or training away from home;

(F) looking for a job away from home. Refer to OAC 340:40-7-8(a)(6); and

(G) vacation time for a child. When a child goes to stay with:

(i) someone other than a natural or adoptive parent for a vacation, household composition, income, and need is based on the usual home situation. The person the child is staying with must also meet the need factor for child care; or

(ii) a non-custodial natural or adoptive parent, that parent must apply for subsidized child care benefits for that time frame based on his or her own household's eligibility.

(2) If a child lives with each parent for part of the month, refer to (d) ~~in~~of this Section.

(3) If a child lives with a parent for part of the month and a caretaker for the rest of the month, the child's eligibility is based on the parent meeting the eligibility factors per OAC 340:40-7. The caretaker must also meet a need factor per OAC 340:40-7-7 during the time he or she has physical custody of the child.

(d) **Joint or shared custody.** When parents separate or divorce and share custody of their child, either voluntarily or through a court order, the worker considers each parent's eligibility separately as well as his or her income. If only one parent qualifies for subsidized child care benefits, only the days and hours of care needed while that parent has physical custody of the child are approved. If both parents qualify for subsidized child care benefits, each parent is approved only for the days and hours that parent has physical custody and meets a need factor.

**340:40-7-11. Sources of income considered**

(a) **Sources of income considered.** Income may be received periodically or at irregular intervals. All income, unless specifically excluded per OAC 340:40-7-12, is considered in determining monthly gross income. Income is classified as earned or unearned income.

(b) **Earned income.** Earned income means total money earned by a person through the receipt of wages, salary, commission, or profit from activities in which the person is engaged as self-employed or as an employee. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income when payments are employer funded and the person remains employed.

(1) **Wages.** Wages include total money earned for work performed as an employee including armed forces pay, commissions, tips, piece-rate payments, longevity payments, and cash bonuses before any deductions are

made, such as taxes, bonds, pensions, union dues, credit union payments, and cafeteria plans.

(A) Countable wages for military personnel include any allowance included on the earnings statement, such as the Basic Allowance for Housing (BAH) and the Basic Allowance for Subsistence (BAS).

(B) Only the portion of the cafeteria plan the client controls is counted as income.

(C) Reimbursements for expenses, such as a uniform allowance or transportation costs, other than daily commuting, are subtracted from gross income.

(D) Payments made for annual leave, sick leave, or severance pay are considered earned income during the month such income is received whether paid during employment or at termination of employment.

(E) Wages that are garnisheed or diverted and paid to a third party are also counted as income.

(2) **Self-employment.** Self-employment income is considered based on procedures listed in this subsection.

(A) **Persons considered self-employed.** A person is considered self-employed when:

(i) he or she declares himself or herself to be self-employed;

(ii) there is an employer/employee relationship and the employer does not withhold income taxes or Federal Insurance Contributions Act (FICA), even when required to do so by law; or

(iii) the employer withholds taxes and the person provides proof he or she files taxes as self-employed.

(B) **Records used and income calculation.** The worker uses the records described in (i) through (iii) of this subparagraph to calculate income. When the person reports a loss instead of a profit on the business, the worker does not deduct the loss from other household income.

(i) When the person filed a federal income tax return for self-employment income for the most recent year, whether the person's income is derived from his or her own business or from working for an employer, the worker uses the net self-employment income shown on the person's federal income tax return and divides the income by 12 or the number of months the business has been in existence or the person started work for the employer, when less than 12 months. The worker verifies the person's start date with the employer when the person states he or she has not worked for the employer for at least 12 months.

(ii) When the person did not file an income tax return for the most recent tax year for his or her own business, the worker calculates self-employment income using the person's business records for the last 12 months or the number of months the business has been in existence when less than 12 months. When the client declares he or she has business expenses, the worker subtracts 50~~%~~percent of the gross self-employment income to arrive at the net profit.

(iii) When the person works for an employer, did not file a federal tax return as self-employed, and receives earnings from an employer, the person must provide proof of the last 12 months of income from the employer. The worker divides the gross income by 12 or the number of months the person has worked for the employer to determine monthly income. When the person declares he or she has business expenses, the worker subtracts 50~~%~~percent of the gross self-employment income before dividing the income by the applicable number of months to determine monthly income.

(C) **Profit sharing.** Households who operate S corporations, general or limited partnerships, or limited liability companies may receive profit sharing that is reported on the household's personal income tax return. When a household member:

(i) actively participates in the operations, the income from profit sharing is considered part of the household's self-employed earned income; or

(ii) does not actively participate in the operations, the income from profit sharing is considered part of the household's unearned income.

(D) **Monthly self-employment income.** Self-employment income received on a monthly basis is normally averaged over a 12-month period. When the averaged amount does not accurately reflect the household's actual monthly circumstances because the household has experienced a substantial increase or decrease in income, the worker calculates the self-employment income based on anticipated earnings.

(E) **Seasonal self-employment.** Self-employment income intended to meet the household's needs for only part of the year is averaged over the period of time it is intended to cover.

(F) **Annualized self-employment income.** Self-employment income that represents a household's annual support is averaged and annualized over a 12-month period, even when the income is received in a short time period.

(i) If the averaged annualized amount does not accurately reflect the person's actual monthly circumstances because the person experienced a substantial increase or decrease in income, the worker calculates the self-employment income on anticipated earnings.

(ii) The worker does not calculate self-employment income on the basis of prior earnings, such as income tax returns, when an increase or decrease of business has occurred.

(I) When the person has received the self-employment income for less than 12 months, the income must be averaged over the

applicable number of months and the monthly amount projected for the coming year.

(II) When the person has received the self-employment income for a short time and there is insufficient data to make a reasonable income projection, the worker does not consider income from this source until the ~~review~~renewal is due. At the ~~review~~renewal, the worker averages income over the number of months received until a full year's information is available.

(G) **Income from rental property.** Income from rental property is considered self-employment income. ~~8~~9

(H) **Income from room and board.** Payments from roomers or boarders are considered self-employment when the roomer or boarder is paying a reasonable amount. When the roomer or boarder is an adult non-relative opposite sex individual (ANROSI), OAC 340:40-7-6(b)(4) applies.

(3) **On-the-job training.** Earned income from regular employment for on-the-job training (OJT) is considered as earned income. This includes OJT provided under Sections 204(b)(1)(c) or 264(c)(1)(A) of the Workforce Investment Act for persons 19 years of age or older.

(4) **Workforce Investment Act (WIA).** Income earned in OJT positions provided under Section 134 of WIA is considered earned income for persons who are 19 years of age and older. On-the-job training provided must be full-time positions, and there must be a contract between WIA and the employer for each individual position. This does not include classroom training and institutional training or intern assignments sponsored by WIA, even when an hourly amount is paid for such training. Refer to OAC 340:40-7-12(24)(G) for other types of excluded WIA income.

(5) **Title I payments of Domestic Volunteer Services Act.** Payments under Title I of the Domestic Volunteer Services Act of 1973 as amended [P.L. 93-113] are considered income unless ~~they are~~ excluded per OAC 340:40-7-12.

(6) **Earnings of children.** Earned income of a minor parent is treated as adult earned income. Earnings of other children 17 years of age and younger who are under the parental control of an adult household member are excluded per OAC 340:40-7-12.

(c) **Unearned income.** Unearned income is income a person receives for which the person does not put forth any daily, physical labor. Types of income listed in paragraphs (1) through (10) of this subsection are considered unearned income.

(1) **Assistance payments.** Assistance payments include state means tested programs, such as Temporary Assistance for Needy Families (TANF), including Supported Permanency benefits, State Supplemental Payment (SSP) to the aged, blind, or disabled, and Refugee Resettlement Program (RRP) cash assistance.

(2) **Pensions, disability, and Social Security benefits.** Annuities, pensions, retirement benefits, disability benefits from either government or private sources, or Social Security survivor benefits are considered unearned income. When a minor child receiving Social Security benefits no longer lives with the payee receiving the Social Security benefits, only the portion of the child's Social Security benefit that is used to meet the minor child's needs is considered income. This may include cash given directly to the minor child or money paid to a third party for room and board for the minor child. The parent or caretaker or, when appropriate, the minor child must take action to become the payee within 90 calendar days as required ~~at~~per OAC 340:40-7-9(d). When action is not taken within 90 calendar days, the worker counts the total Social Security benefit as income.

(3) **Supplemental Security Income (SSI).** SSI is considered unearned income.

(4) **Unemployment and workers' compensation.** Income from unemployment insurance benefits or workers' compensation is counted as unearned income.

(5) **Child support, court-ordered or third party paid child care, and alimony.** Child support, child care payments, and alimony payments, whether court-ordered or voluntary, made directly to the household from non-household members are counted as unearned income.

(A) When a child care payment is paid directly to the child care provider, it is not considered income for the client.

(B) When the absent parent reports he or she is paying a portion of the client's family share co-payment to the child care provider, the only action taken by the worker is to record this in the case record.

(C) When the absent parent or another third party, such as an employer, is making a payment to the provider in addition to the client's co-payment, it is considered as an additional co-payment that must be met before the Oklahoma Department of Human Services (OKDHS) makes a subsidy payment to the provider.

(D) Any other payment made to a third party for a household expense must be considered as income when a court order directs the payment be made to the household. Payments for medical support are excluded.

(6) **Veterans compensation, pensions, or military allotments.** Annuities, pensions, disability compensation, military allotments, servicemen dependent allowances, and similar payments are considered unearned income.

(7) **Contributions.** Appreciable contributions recurrently received in cash are considered unearned income except when the contribution is not made directly to the client. To be appreciable, a contribution must exceed $30 per calendar quarter per person.

(8) **Dividends, interest, minerals, and royalties.** Dividends, interest income, income from minerals, royalties, and similar sources are considered unearned income. When income from these sources is received irregularly or

in varied amounts, it is averaged over 12 months. Income from royalties is treated as unearned, self-employment income, subject to (b)(2) of this Section.

(9) **Lump sum payments.** Recurring lump sum payments, including income from earnings, are averaged over the period they are intended to cover.

(10) **Irregular income.** Income received irregularly but in excess of $30 per quarter is considered income unless it is from an excluded income source specifically mentioned at OAC 340:40-7-12. Countable irregular income is averaged over 12 months.

*[OAR Docket #13-889; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 50. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

*[OAR Docket #13-890]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 9. Eligibility And Benefit Determination Procedures
340:50-9-3 [AMENDED]
**(Reference APA WF12-19)**
**AUTHORITY:**
Director of Human Services; Sections 162 and 230.52 of Title 56 of the Oklahoma Statutes; and Section 273.10 of Title 7 of the Code of Federal Regulations.
**DATES:**
**Comment period:**
January 2, 2013 through February 1, 2013
**Public hearing:**
None requested
**Adoption:**
March 18, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed revisions to Subchapter 9 of Chapter 50 amend the rules to: (1) remove obsolete terminology; and (2) update language to reflect current processes used to generate certification and denial notices.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 9. ELIGIBILITY AND BENEFIT DETERMINATION PROCEDURES

**340:50-9-3. ~~Providing certification notices~~Certification and denial notice information**

(a) ~~**Providing notification of eligibility.**~~

~~(1)~~ **Time limit for providing notice.** ~~Every~~The applicant household ~~found eligible~~ is ~~provided with a computer-generated notice of eligibility as soon as a determination is made and action is taken. Determination should be made~~entitled to receive a certification or denial notice no later than 30 calendar days after the ~~date of~~ initial application date. ~~If action must be delayed beyond the 30 days, see 340:50-9-4.~~Refer to OAC 340:50-9-4 when a processing delay occurs.

(b) **Notices.** A computer-generated notice is sent to applicant households immediately following eligibility determination and worker action to approve or deny benefits.

(1) **Certification notice.** The certification notice informs the household of:

(A) the beginning date and length of the certification period;

(B) the benefit amount of the allotment and any variation in the benefit level based on:

(i) changes anticipated at the time of certification~~.~~; or

(ii) differences caused because retroactive benefits are calculated using different income or the initial month's benefits are prorated; and

~~(iii) If the applicant is being certified retroactively and will receive benefits for both the month of application and the current month's benefits, the notice will explain that the benefits received will cover more than one month. The notice informs the household of the beginning and ending dates of the certification period. The notice also advises the household of~~ its right to a fair hearing ~~and of the name and telephone number of the worker to contact for additional information~~.

(2) ~~**Notices of**~~**Expedited certification and expiration notice.** ~~Notices of certification and expiration are computer-generated.~~

~~(A)~~ ~~**Expedited applications.** In cases where a household's application is approved~~ When the worker approves food benefits on an expedited basis ~~without verification, the notice shall explain that the household must provide for verification which was waived. This notice of eligibility will also provide~~because ongoing eligibility has not been determined, in addition to information contained in (b)(1) of this Section, the notice:

(A) explains that certain information was postponed because the household qualifies for expedited eligibility processing;

(B) ~~**Household certified for one or two months.** Households certified for one or two months receive a combined notice informing them of the beginning and the ending date of their certification period, as well as the expiration date and the conditions for making timely reapplication.~~includes the expiration date; and

(C) the conditions for making timely reapplication.

~~(3) **Notices of recertification.** For households whose prior certification was for no more than two months that have filed application by the 15th day of the last month of their certification period and determination can be made, a computer generated notice of eligibility or a notice of denial will be issued when the action is processed. If action cannot be taken within 30 days of the date the household had an opportunity to obtain its last allotment, the worker is responsible for manually issuing a notice explaining the delay.~~

(3)~~(b)**Providing notification of ineligibility**~~**Denial notice**.~~A computer generated notice of denial will be sent when the action is teleprocessed to all those households found ineligible, either at the point ineligibility is established, the client refuses to cooperate, or the household has failed to provide necessary verifications in order to determine their eligibility by the end of the 30-day period. The notice contains the basis~~The denial notice informs the household of:

(A) the reason for the denial~~, the household's~~; and

(B) its right to request a fair hearing~~, and the telephone number of the county office to contact for additional information. The client may call the county office to ask if there is free legal representation available in the county~~.

*[OAR Docket #13-890; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 61. REPATRIATION PROGRAM

*[OAR Docket #13-891]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions [NEW]
340:61-1-1 through 340:61-1-4 [NEW]
**(Reference APA WF 12-25)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes; Section 1113 of Title XI of the Social Security Act (Assistance for U.S. Citizens Returned from Foreign Countries); an Oklahoma Department of Human Services (OKDHS) agreement with the Department of Health and Human Services; an Administration for Children and Families (ACF) Fact Sheet; and the referral information packet received from the Office of Refugee Resettlement.
**DATES:**
**Comment period:**
February 1, 2013 through March 4, 2013
**Public hearing:**
None requested
**Adoption:**
March 18, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed rules are created for the Repatriation Program (RP) and issued in Chapter 61 to: (1) describe the purpose and legal base of the program; and (2) issue rules regarding applicant eligibility, referral information, OKDHS responsibilities, and types of temporary assistance.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### 340:61-1-1. Purpose

The purpose of this Chapter is to describe the rules governing the Oklahoma Department of Human Services (OKDHS) Repatriation Program.

### 340:6-1-12. Legal base and availability of funds

(a) The United States (U.S.) Repatriation Program (RP) was established in 1935 by Section 1113 of Title XI of the Social Security Act (Assistance for U.S. Citizens Returned from Foreign Countries) to provide temporary assistance to U.S. citizens and their dependents who have been identified by the Department of State as having returned, or been brought from a foreign country to the U.S. because of destitution, illness, war, threat of war, or a similar crisis, and are without available resources to meet their needs. The total amount of temporary assistance provided under this Section shall not exceed $1,000,000 during any fiscal year except fiscal year 2010.

(b) The Department of Health and Human Services (DHHS), Office of Refugee Resettlement (ORR) manages this program. The RP is administered by the state in which the repatriated citizen chooses to relocate, with up to 100 percent reimbursement claimed from federal funds.

(c) Non-emergency repatriation for individuals and their dependents is coordinated by the Oklahoma Department of Human Services per agreement dated October 9, 1980 with the

DHHS Social Security Administration Office of Family Assistance.

**340:61-1-3. Program eligibility and responsibilities**

(a) **Applicant eligibility.** The Office of Refugee Resettlement (ORR) or contracted agency staff determines the repatriated individual's eligibility for the Repatriation Program (RP). Assessment of the repatriate's available resources, including identification of services or assistance the repatriate is receiving or is able to receive is necessary to determine eligibility for the RP.

(1) Temporary assistance is not an entitlement.

(2) The RP is voluntary and the repatriate may refuse to accept services.

(3) The repatriate may be eligible for temporary assistance in the form of a loan for up to 90 calendar days from the date the repatriate re-enters the United States (U.S.) if the repatriate signs a repayment agreement.

(4) Minors and adults found not competent to make decisions are not obligated to sign a repayment agreement.

(5) To determine whether the repatriate is eligible for repatriation assistance, it must be established that necessary services or assistance are unavailable to the repatriate via any alternative resources.

(6) Certain temporary assistance may be furnished after the 90 calendar day period ends if the:

(A) repatriate submits an extension request with supporting documentation included prior to the end of the 90 calendar day eligibility period; and

(B) ORR finds that the circumstances involved necessitate or justify the furnishing of such assistance beyond the 90 day limit.

(7) The repatriate must notify the refugee coordinator of address changes during the period of time the repatriation case is open. He or she is expected to continue to notify ORR of address changes after case closure until the repatriation loan is paid in full.

(8) The repatriate's case may be closed before the 90 calendar day period expires when the:

(A) repatriate's case contains an unaccompanied child and the child enters foster care upon arrival in the U.S. or is released to a parent or relative not requesting services;

(B) repatriate becomes self-sufficient and has access to necessary benefits, housing, and other services and no longer needs the temporary assistance;

(C) ORR discovers the repatriate has access to other sources of income;

(D) repatriate dies upon arrival in the U.S.; or

(E) repatriate who was destitute or without available resources in the foreign country, is able to regain access to financial resources such as Social Security or Supplemental Security Income benefits or is staying in a hospital or nursing facility.

(b) **Referral information packet.** ORR mails a referral information packet to the Oklahoma Department of Human Services (OKDHS), Adult and Family Services (AFS) Temporary Assistance for Needy Families (TANF) Section for processing. The referral information packet contains documents for the repatriate and OKDHS. Items in the packet include:

(1) a welcome letter for the repatriate explaining that:

(A) any funds issued are in the form of a loan that must be repaid by the repatriate;

(B) upon request, the OKDHS staff person will explain the documents included in the welcome packet;

(C) OKDHS staff refers the repatriate for services available within the community or gives the repatriate information about available services; and

(D) if needed and requested, the refugee coordinator coordinates other service requests for the repatriate;

(2) the repatriate's rights and obligations;

(3) documents requiring the repatriate's signature prior to funds being issued;

(4) assessment information regarding the repatriate and his or her service needs; and

(5) procedural information for OKDHS staff.

(c) **OKDHS responsibilities regarding the RP.** Upon receipt of the referral information packet, the refugee coordinator in the OKDHS AFS TANF Section is responsible for:

(1) confirming the repatriate's arrival date and time and arranging for an OKDHS staff person to meet the repatriate at the airport;

(2) being the contact person for the repatriate and ORR or its contracted agency staff;

(3) coordinating services for the repatriate during the 90 calendar day temporary assistance period;

(4) coordinating completion of forms and documents necessary to issue funds and receive reimbursement from the ORR or its contracted agency;

(5) monitoring the repatriate's case at different intervals to ensure he or she continues to meet eligibility requirements and determine if further assistance is needed;

(6) providing periodic updates regarding the repatriate to ORR or its contracted agency staff;

(7) submitting extension requests as quickly as possible;

(8) maintaining all records concerning the repatriate for at least three years from the date the final expenditure report is submitted; and

(9) upon case closure, completing a survey and submitting a closing summary to ORR that includes information about the funds expended and services provided to the repatriate and the repatriate's current address.

**340:61-1-4. Repatriation Program (RP) services provisions**

(a) **Temporary assistance.** The RP defines temporary assistance as cash payments, medical care (including counseling), temporary or permanent housing, transportation, and other goods and services necessary for the health or welfare of the repatriate.

(1) All funds are issued in the form of a loan and must be repaid to the United States Government.

(2) The repatriate may request a waiver or deferral of repayment of funds expended on his or her behalf within 30 calendar days of receiving a demand for payment letter from the Office of Refugee Resettlement (ORR) or its contracted agency. The letter advises the repatriate who to contact to request the waiver or deferral of payment.

(b) **Cash assistance.** The repatriate is eligible to receive a cash assistance loan equivalent to three months of Temporary Assistance for Needy Families (TANF) for the same family size as shown on Schedule IX of Appendix C-1, Maximum Income, Resource, and Payment Standards. The cash assistance is issued after the repatriate signs the repayment agreement.

(c) **Social services.** Upon receipt of the information referral packet, the Adult and Family Services (AFS) refugee coordinator reviews the assessment information provided regarding the repatriate and his or her dependents to determine the repatriate's identified social service needs.

(1) In addition to or instead of cash assistance, the assessment information may indicate the repatriate needs other types of temporary assistance.

(2) The refugee coordinator and local county staff develop a tentative plan to meet the repatriate's social service needs prior to the repatriate's arrival. This plan is presented to the repatriate at the airport. The repatriate is free to accept or reject any part of the service plan. Refer to OAC 340:61-1-3 regarding minors and mentally incompetent adults.

(3) The service plan includes helping the repatriate apply for all public assistance he or she appears eligible to receive including programs administered by the Oklahoma Department of Human Services (OKDHS) and other local agencies. RP funds are not expended when the services are available free of charge.

(A) Public assistance benefit programs administered by AFS include TANF, Supplemental Nutrition Assistance Program food benefits, Child Care Subsidy Program, and SoonerCare (Medicaid) medical benefits.

(B) Depending on the repatriate's circumstances, he or she may also be eligible for services administered by other divisions within OKDHS including the Developmental Disability Services Division, Aging Services Division, and Oklahoma Child Support Services.

(C) Public assistance available through other local agencies may include housing assistance, benefits from the Social Security Administration, food banks, help finding a job, transportation, clothing closets, or medical clinics.

(4) The OKDHS staff person meeting the repatriate at the airport presents all available options to the repatriate prior to signing a repayment agreement. This allows the repatriate to make an informed decision about accepting an RP loan.

(d) **Medical assistance.** When the repatriate needs immediate medical attention, the refugee coordinator locates a medical provider willing to treat the repatriate upon arrival. ORR reimburses the medical provider reasonable, allowable, and allocable expenses that are not covered by an outside source such as insurance or SoonerCare (Medicaid).

*[OAR Docket #13-891; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 75. CHILD WELFARE

*[OAR Docket #13-897]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions of Child Welfare Services
Part 9. Rules Regarding Human Immunodeficiency Virus (HIV)
340:75-1-113 [AMENDED]
Subchapter 3. Child Protective Services
Part. 1. Purpose, Definitions, and Hotline Protocol
340:75-3-100 [NEW]
Part 3. Child Safety Evaluation Criteria and Procedure [NEW]
340:75-3-300 [NEW]
Subchapter 6. Permanency Planning
Part 7. Family and Child Individualized Service Planning Components
340:75-6-40.9 [NEW]
Part 8. ~~Role of the~~ Child Welfare ~~Worker~~Specialist Role
340:75-6-48.1 [AMENDED]
Part 11. Permanency Planning and Placement Services
340:75-6-85 [AMENDED]
Subchapter 7. Foster Home Care
Part 4. Roles and Responsibilities
340:75-7-38 [AMENDED]
Part 25. Emergency Foster Care Program
340:75-7-262 [AMENDED]
Subchapter 15. Adoptions
Part 10. Integrated Family Assessment and Preparation Process
340:75-15-87 [AMENDED]
**(Reference WF 12-10)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes (56 O.S. § 162); Oklahoma Children's Code 10A O.S. § 1-1-101 et. seq. related to existing statutory cites and language expanded in rule; House Bill (HB) 2251 and 10A O.S. §§ 1-2-102 and 1-1-105 related to the drug-endangered child; HB 3135 and 10A O.S. §§ 1-6-102 and 1-6-105 related to disclosure of confidential information; Senate Bill (SB) 1183 and 10 O.S. § 7505-5.3 and 10A O.S. § 1-7-111 related to the use of Department of Public Safety (DPS) Motor Vehicle Report for prospective foster and adoptive parents; HB 2300 and 10A O.S. § 1-1-105 related to child protective services investigation findings; 10A O.S. § 1-4-806 related to trial reunification background checks, 10A O.S. § 1-4-809 related to reasonable efforts findings by the court; HB 3049 and 57 O.S. § 590 related to the parent who is a registered sex offender; and HB 3134 and non-codified language related to the OKDHS reorganization.
**DATES:**
**Comment period:**
January 2, 2013 through February 1, 2013
**Public hearing:**
None requested
**Adoption:**
March 18, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013

**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed revisions to Subchapters 1, 3, 4, 6, 7, 13, 15, 18, and 19 of Chapter 75: (1) amend the rules to comply with federal and state statutes and regulations and Oklahoma Pinnacle Plan requirements related to the provision of child welfare services; and (2) update division, unit, and position titles consistent with the Oklahoma Department of Human Services (OKDHS) reorganization.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS OF CHILD WELFARE SERVICES

## PART 9. RULES REGARDING HUMAN IMMUNODEFICIENCY VIRUS (HIV)

**340:75-1-113. ~~Purpose, legal base, and definitions regarding HIV~~Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) requirements related to the child in Oklahoma Department of Human Services (OKDHS) custody**

(a) **~~Purpose~~Care and treatment for the child in OKDHS custody diagnosed with AIDS or HIV.** ~~Children~~

(1) The child in ~~Oklahoma Department of Human Services (~~OKDHS~~)~~ custody ~~who are~~has special needs when the child is:

(A~~1~~) at risk for~~AcquiredHuman Immunodeficiency Syndrome Virus(AIDS)~~HIV;

(B~~2~~) seropositive for~~Human Immunodeficiency Virus (~~HIV~~) seropositive~~; or

(C~~3~~) medically diagnosed ~~with~~to have AIDS ~~have specific needs that must be addressed~~.

(2) The principles of care and treatment ~~are~~include:

(A) ~~prevention of transmission by educating persons about~~providing education regarding the transmission of HIV and precautions exercised to prevent transmission;

(B) ~~provision of~~providing therapeutic intervention for ~~children~~the child found at risk of exposure to HIV;

(C) ~~protection of~~protecting persons by universal application of infection control procedures; and

(D) ~~protection of~~protecting the child's right to privacy.

(b) **Legal ~~base~~authority to provide care for the child in OKDHS custody with HIV or AIDS.**

(1) Sections ~~7002-2.1~~1-7-102 and ~~7004-1.1~~1-7-103 of Title ~~10~~10A of the Oklahoma Statutes (~~10 O.S. § 7002-2.1 and 7004-1.1~~10A O.S. §1-7-102 and 1-7-103) ~~mandate~~require OKDHS to provide ~~for the~~ care and treatment of ~~children~~thechild in OKDHS custody.

(2) Per ~~10 O.S. § 7003-5.4~~10A O.S. § 1-7-104, OKDHS provides the child's placement provider with sufficient medical information to enable the placement providers to care for the child safely and appropriately.~~A~~The placement provider for ~~a~~the child in OKDHS custody may request OKDHS to provide:

(A) contagious or infectious screening examinations or tests ~~on a~~of the child; and

(B) the results of the child's examinations or tests to the placement provider.

(c) **Definitions.** The following words and terms, when used in Part 9 of this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Acquired Immunodeficiency Syndrome (AIDS)"** means a condition caused by a virus, Human Immunodeficiency Virus (HIV), that attacks the body's natural immune system, reducing the ability to fight off infections and diseases.

(2) **"AIDS counseling"** means counseling provided by a designated person who:

(A) is trained and certified by Oklahoma State Department of Health or American Red Cross in the health implications of ~~AIDS~~HIV/AIDS; and

(B) offers supportive services for a person dealing with suspected or actual HIV infection or ~~AIDS~~HIV/AIDS.

(3) **"Confidential Human Immunodeficiency Virus (HIV)-related information"** means ~~any~~ information:

(A) ~~in the possession of a person who obtains the information~~obtained pursuant to a release of confidential HIV-related information;

(B) regarding a person who:

(i) is the subject of an HIV-related test; or

(ii) has HIV infection, HIV-related illness, or AIDS; or

(C) that identifies or may identify a person with one or more such conditions, including information pertaining to the person's contacts.

(4) **"Exposure to HIV"** means the blood, semen, vaginal fluids, ~~or~~ breast milk, or other bodily fluid of an HIV infected person comes in contact with the blood stream or a mucous membrane of an uninfected person.

(5) **"High risk behaviors"** means activities or conditions that place a person at risk of exposure to HIV due to contact with certain bodily fluids of a person who is infected with HIV, such as:

(A) unprotected sexual contact between such persons;

(B) sharing syringe needles among such persons;

(C) perinatal transmission when the mother is HIV infected; and

(D) breast feeding when the mother is HIV infected.

(6) **"HIV"** means the virus that causes AIDS.

(7) **"HIV test"** means a blood test used to detect the presence of antibodies to HIV.

(8) **"Informed consent"** means consent obtained from a person who:

(A) understands and is competent to make an intelligent decision about the request for consent and any resulting consequences;

(B) understands any risk involved and the procedures to be undertaken; and

(C) volunteers to consent.

(9) **"Need-to-know"** means a person who needs to be informed about the HIV status of a child due to the person's direct responsibility or accountability for the child's care.

(10) **"Reduction of risk to HIV exposure"** means reduced exposure to HIV through universal application of infection control procedures. Exposure occurs when ~~one of four body~~ fluids such as, semen, blood, vaginal fluids, ~~and~~ breast milk, or other bodily fluids from an infected person comes in contact with the bloodstream or a mucous membrane of an uninfected person.

(11) **"Release of confidential HIV-related information"** means disclosure through written authorization, including informed written consent for testing and release of HIV test results, that is signed by the person who has the authority to consent.

(12) **"Serologic testing and screening"** means blood tests used to detect antibodies to HIV, including Enzyme-Linked Immunosorbent Assay (ELISA) and Western Blot.

(13) **"Seronegative"** means ~~a negative result in~~ a blood test ~~for HIV~~indicates a negative result for the presence of a disease such as AIDS.

(14) **"Seropositive"** means ~~a positive~~the result ~~in~~of a blood test~~ indicating that the person has developed antibodies to HIV~~indicates the presence of a disease such as AIDS.

(15) **"Specialized AIDS trainer"** means a person who:

(A) is trained by Oklahoma State Department of Health or American Red Cross in the health implications of HIV and AIDS; and

(B) provides AIDS-related training.

(16) **"Transmission of HIV"** means passing or spreading HIV infection through:

(A) sexual contact, including oral, vaginal, or anal contact, with an infected person's blood, semen, ~~or~~ vaginal secretions, or other bodily fluids;

(B) exposure to infected blood or blood products through needles, occupational exposure, or transfusions; or

(C) ~~perinatal~~ exposure from a mother, at or around the time of birth, who is HIV infected ~~with HIV~~, to her fetus or newborn ~~or shortly after birth, probably through breast milk~~. ~~HIV must be present in sufficient quantity for transmission.~~

(17) **"Universal precautions"** means an approach to infection control in which all human blood and certain human body fluids are treated as infected with bloodborne pathogens, such as bacteria, HIV, ~~and~~or other viruses or disease.

(d) **Required AIDS and HIV educational training for CW staff and placement providers.** Educational training regarding AIDS and HIV infection is required for Child Welfare (CW) staff and placement providers.

(e) **Certified HIV/AIDS counselor role.** OKDHS provides trained certified HIV/AIDS counselors who participate in HIV pre-test and post-test activities.

(f) **HIV confidentiality.**

(1) Per 63 O.S. § 1-502.2, except as otherwise provided by law, all information and records concerning any person who may have a communicable or noncommunicable disease required to be reported by Oklahoma statuteare confidential. 10A O.S. §1-6-101 defines agency records as records prepared, obtained, or maintained by the agency and would include the medical records of a child in OKDHS custody, including information regarding any communicable or sexually transmitted disease, pertaining to a child. 10A O.S. § 1-6-103 provides OKDHS records may be inspected and contents disclosed without a court order to certain persons showing proper credentials and pursuant to their lawful duties. HIV-related information about the child, or any person who is a member of the child's case record, may be disclosed to:

(A) the court having the child currently before it in any proceeding pursuant to Title 10A of the Oklahoma Statutes;

(B) a district attorney (DA) or employee of the DA's office in the course of his or her official duties pursuant to Title 10A of the Oklahoma Statutes;

(C) the attorney representing a child who is the subject of a proceeding pursuant to Title 10A of the Oklahoma Statutes;

(D) others entitled to access CW records without a court order, per 10A O.S. §1-6-103; and

(E) per 10A O.S. §1-7-104, the placement provider, if this information is known to OKDHS.

(2) Disclosure of the child's HIV serological status is limited to the child's placement provider, court, DA, and child's attorney. OKDHS consults with the judge and DA to determine the appropriate method of disclosure of HIV-related information to the court and DA to prevent inadvertent disclosure by inclusion of the information in the court file regarding the child. Others entitled to access to CW records without a court order, per OAC 340:75-1-44, are provided communicable disease information on a need-to-know basis.

(3) A person advised of another person's HIV status, with the exception of the court, DA, or child's attorney,

signs and dates a statement similar to the statement of confidentiality in (A) of this paragraph.

(A) This information is disclosed to you from confidential records that are protected by state law. State law prohibits you from making any further disclosure of this information without obtaining specific written authorization, per Part 9 of OAC 340:75-1, or as otherwise permitted by law. Any unauthorized further disclosure is in violation of state law and may result in civil or criminal sanctions as provided by Oklahoma Statutes.

(B) A general authorization for release of medical or other information is not sufficient authorization for further disclosure of a person's HIV status.

(g) **Early identification of communicable disease.** Per 10A O.S. § 1-7-103, OKDHSprovides medical care as is necessary to preserve the child's health and protect the health of others in contact with the child.

(h) **Placement provider's request for HIV test.** When requested by the placement provider, OKDHS provides for the HIV examinations or tests on the child based on the Centers for Disease Control guidelines for time and frequency of testing. Per 10A O.S. §1-7-104 OKDHS provides the child's placement provider with sufficient medical information to enable the placement provider to care for the child safely and appropriately. The medical information includes, but is not limited to:

(1) any medical or psychological conditions;

(2) diseases, illnesses, accidents, allergies, and congenital defects;

(3) the child's Medicaid card or information on any other third-party insurer, if any; and

(4) Immunization history.

(i) **Authorization for HIV testing.** When requested by the child's placement provider, per 10A O.S. § 1-7-104, OKDHS obtains authorization for an HIV test for the child and release of the test results to the placement provider. Authorization for HIV testing or release of HIV test results may be obtained by informed written consent of the child's parent or legal guardian or court order.

## SUBCHAPTER 3. CHILD PROTECTIVE SERVICES

## PART 1. PURPOSE, DEFINITIONS, AND HOTLINE PROTOCOL

### 340:75-3-100. Child protective services purpose, philosophy, legal authority, and scope

(a) **Child protective services purpose.** Child protective services (CPS) is a child welfare services provision that focuses on preventing, identifying, and treating child abuse and neglect and ensuring child safety. Efforts are made to maintain and protect the child in the child's own home when safety threats can be managed and controlled. The primary purpose of CPS intervention is to:

(1) protect the child;

(2) assess family strengths and needs; and

(3) provide services to remedy the conditions and behaviors that cause abuse, neglect, or safety threats.

(b) **Child protective services philosophy.** The child welfare (CW) program emphasizes child safety and family preservation when the child is safely maintained within the family. While family reunification or rehabilitation is an optimum means for protecting the child, the right to family integrity is limited by the child's right to be protected from abuse and neglect, per Section 1-1-102 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-1-102).

(1) Consistent with federal and state requirements:

(A) reasonable efforts are made when possible to prevent or eliminate the need for the child's removal; or

(B) intervention is directed toward child and family reunification when the child will be safe in the home.

(2) When the child cannot be safely maintained in the home, court intervention and the child's removal from the home may be necessary.

(3) Oklahoma Department of Human Services (OKDHS) recognizes that when the child is removed from the home, timely achievement of the child's permanency plan is in the child's best interests.

(c) **Legal authority for child protective services.**

(1) 10A O.S. §§ 1-2-101 through 1-2-110 requires that suspected abuse and neglect be reported to OKDHS. OKDHS conducts a safety analysis and forwards the assessment conclusions or investigation findings to the appropriate district attorney's (DA's) office.

(2) 10A O.S. § 1-2-108 requires that OKDHS maintain an information system of the assessment conclusions or investigation findings in addition to other child abuse and neglect related information.

(3) 10A O.S. § 1-4-201 sets forth methods by which custody of a child may be assumed. Law enforcement officers or designated employees of the court are authorized to assume protective custody without a court order in defined circumstances, or the court may issue an order for emergency custody after an application, supported by an affidavit, is submitted by the DA to the court.

(d) **Scope of child protective services.**

(1) CPS intervention is mandated by 10A O.S. § 1-1-102 when a child is abused, neglected, drug-endangered, or at risk of significant harm because of willful acts, intent to act, or omissions by the person responsible for the child's (PRFC) health, safety, or welfare. CPS addresses intra-familial abuse or neglect and assesses or investigates allegations of abuse or neglect when the perpetrator is identified as:

(A) the child's custodial or noncustodial parent;

(B) the child's legal guardian or custodian;

(C) an adult residing in the child's home including an adult who is cohabitating with the child's parent; or

(D) a person other than a PRFC when it is necessary to determine whether the PRFC's actions contributed to the child's abuse or neglect and reflects the PRFC's unwillingness or inability to protect the child.

(2) OKDHS is mandated per 10A O.S. § 1-2-105 to investigate alleged abuse or neglect by a PRFC as defined in 10A O.S. § 1-1-105 that includes:

(A) a foster parent per OAC 340:75-3-410;

(B) an owner, operator, or employee of a child care facility, child care center, or child care home, as defined in 10 O.S. § 402, whether licensed or unlicensed per OAC 340:75-3-110 and 340:75-3-420; and

(C) an agent or employee of a public or private residential home institution facility or day treatment program as defined by 10 O.S. § 175.20.

(3) Except when employed in a child care facility, school teachers and officials, OKDHS employees, and other persons providing services to the child are not PRFCs.

(4) Reports alleging child abuse or neglect in settings above the foster care level are investigated by the Office of Client Advocacy per OAC 340:2-3-32.

## PART 3. CHILD SAFETY EVALUATION CRITERIA AND PROCEDURE

### 340:75-3-300. Child safety evaluation

(a) **Evaluating child safety.** Evaluating child safety is a primary child protective services (CPS) function. Safety refers to the child's present security and well-being when the child is assessed to be at risk of abuse or neglect. The safety evaluation is an adaptable and continuous process that is not complete until the child is safe and the case is closed.

(b) **Determining the need for protective or emergency custody.** Oklahoma Department of Human Services (OKDHS) evaluates whether to recommend protective custody or emergency OKDHS custody of a child based on the seriousness of the child's abuse or neglect and whether the child is in need of immediate protection due to an imminent safety threat. A child taken into protective custody by law enforcement is not, by virtue of a standing order considered in OKDHS emergency custody upon the child's admission to a shelter. A child cannot be placed in OKDHS emergency custody per Section 1-4-201 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-4-201) until:

(1) OKDHS has completed a safety evaluation and concluded the child faces an imminent safety threat; and

(2) the court has issued a child-specific emergency custody order.

(c) **Alternatives to protective or emergency custody and safety planning in cases of serious abuse or neglect.** When an alternative to protective or emergency custody is determined appropriate in circumstances where serious neglect or physical harm is documented, Form 04MP054, Immediate Protective Action Plan/ Voluntary Safety Plan, is completed and implemented when the person responsible for the child (PRFC) agrees to cooperate with OKDHS efforts to ensure the child's safety. The safety plan describes the present or impending danger identified by the Child Welfare specialist and addresses actions to be taken to control or eliminate any identified safety threat. The PRFC and any identified monitors, sign the safety plan, agreeing to cooperate with OKDHS oversight to ensure the child's safety.

(d) **Safety planning without court involvement.** The voluntary safety plan is developed and implemented by agreement without court intervention. The implementation of a short-term voluntary safety plan does not preclude OKDHS from recommending court involvement.

(e) **Removal of a child from the home.** A recommendation to remove a child from the home is made when, upon evaluating relevant conditions, a determination is made that:

(1) no in-home safety responses are available or acceptable;

(2) the parent appears unable or unwilling to protect the child;

(3) an emergency exists that prohibits the arrangements of timely resources or services to reduce risk and threats of abuse or neglect are unavailable; or

(4) continued placement in the home is contrary to the child's health, safety, and welfare.

(f) **Placement considerations when the child is removed from the home.** When a child is removed from his or her home, placement preference is given to relatives and persons who have a kinship relationship with the child per 10A O.S. § 1-4-204.

(1) Siblings are placed together in the same home when appropriate and possible.

(2) Placement decisions are made with the long-term best interests of the child in mind.

(g) **Restoration of custody to the parent, legal guardian, or custodian when the child is in protective custody.** When the OKDHS safety evaluation indicates the child does not face an imminent safety threat, OKDHS restores the child to the custody and control of the parent, legal guardian, or custodian per 10A O.S. § 1-4-201. Specific county procedures are followed when a child is released from protective custody by the court.

(h) **Pre-petition removal of a child not in OKDHS custody.**

(1) Reasonable efforts are made to prevent the pre-petition removal of a child from the home unless a documented emergency exists that requires immediate removal. Per 10A O.S. § 1-4-201 and Section 671 of Title 42 of the United States Code (42 U.S.C. § 671), a child is removed from the home prior to the filing of a petition only when there is reasonable suspicion:

(A) the child is in need of immediate protection due to an imminent safety threat; or

(B) the child's circumstances or surroundings are such that continuation of the child in the child's home or in the care or custody of the parent, legal guardian, or custodian would present an imminent safety threat to the child and is contrary to the child's welfare.

(2) A child who is in surroundings that pose an immediate threat to the child may be removed from the home

by law enforcement without a court order. When law enforcement declines to remove the child or when OKDHS is responding to a referral without law enforcement involvement and the child is believed to be in need of immediate protection due to an imminent safety threat, OKDHS prepares an affidavit to present to the district attorney (DA) to request that the DA consider filing an application with the court to obtain an emergency custody order, per 10A O.S. § 1-4-201.

(i) **Pre-petition removal of a foreign national child.** The pre-petition removal of a child from the home, a PRFC, or other caretaker is based on safety considerations related to the child and without regard to the child's citizenship or immigration status.

(j) **OKDHS authority to execute a pre-petition emergency custody order.** Per 10A O.S. § 1-4-201, when the district court issues a pre-petition order placing the child in OKDHS emergency custody pending further hearing, an OKDHS employee may execute the emergency order and physically take the child into custody, in limited circumstances when:

(1) the child is located in a hospital, school, or day care facility; and

(2) it is believed assumption of custody of the child from the facility can occur without risk to the child or the OKDHS employee.

(k) **Medical care for child in protective custody.**

(1) When the child in protective custody is in need of emergency medical care prior to the emergency custody hearing, a peace officer, court employee, or the court may authorize such treatment as necessary to safeguard the child's health or life when:

(A) the treatment is related to the suspected abuse or neglect; or

(B) the parent or legal guardian is unavailable or unwilling to consent to treatment recommended by a physician. Before a peace officer, court employee, or the court authorizes treatment based on the unavailability of the parent or legal guardian, law enforcement exercises diligence to locate the parent or guardian, if known, per 10A O.S. § 1-3-102.

(2) When law enforcement, the parent, or guardian is unwilling to consent to emergency medical care, the DA is contacted to obtain a court order for the child's treatment.

(l) **Notification, disposition, and release of the child in pre-petition emergency custody.**

(1) The court may provide, in an administrative order or rule issued pursuant to 10A O.S. § 1-4-201, for the disposition of the child taken into custody and notification to the court of the assumption of custody. The administrative order or rule may include a process for release of the child prior to an emergency custody hearing. Specific county procedures are followed when the child is released from emergency custody prior to the emergency hearing.

(2) The court may order the child released to the parent, legal guardian, custodian, or to any responsible adult without conditions or under conditions the court finds necessary to ensure the child's safety, health, or well-being.

(m) **Post-petition removal of the child in OKDHS custody.** Following the filing of a deprived petition, OKDHS may remove the child directly from the child's home when continued placement in the home is contrary to the child's health, safety, or welfare and the child is in OKDHS legal custody, unless ordered placed in the home by the court.

(1) To ensure the safety of the child and the OKDHS employee, law enforcement assistance is requested in these situations.

(2) Refer to 10A O.S. § 1-4-806 when the child is in trial reunification status.

(n) **Child who has left Oklahoma.** When the child who is the subject of an emergency custody or a pick-up order, has left Oklahoma prior to execution of the order, enforcement of the emergency custody or pick-up order and recognition of Oklahoma's jurisdiction by the another state must occur to have the child returned to Oklahoma. Each circumstance is managed according to the laws and procedures in the state where the child is located.

## SUBCHAPTER 6. PERMANENCY PLANNING

## PART 7. FAMILY AND CHILD INDIVIDUALIZED SERVICE PLANNING COMPONENTS

### 340:75-6-40.9. Termination of parental rights

(a) **Effect of termination of parental rights.** Per Section 1-4-904 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-4-904), the termination of parental rights (TPR) terminates the parent-child relationship including the parent's right to:

(1) custody of the child;

(2) visit the child;

(3) control the child's training and education;

(4) consent to the child's adoption;

(5) the child's earnings;

(6) inherit from or through the child although termination of parental rights does not affect the child's right to inherit from the parent.

(b) **Legal grounds for termination of parental rights.**

(1) Per 10A O.S. § 1-4-904, a court may not terminate a parent's parental rights unless the child is adjudicated deprived prior to or concurrent with the termination of parental rights proceedings and the court makes the finding that TPR is in the child's best interests.

(2) Per 10A O.S. § 1-4-901, a petition or motion for TPR may be filed by the district attorney or by the attorney for the child alleged to be or adjudicated deprived.

(3) Per 10A O.S. § 1-4-904 the court may terminate parental rights on the grounds listed in subparagraphs (A) through (M) of this paragraph.

(A) **Consent.** The parent may consent to termination of his or her parental rights by signing a voluntary consent form to relinquish parental rights.

(i) The written voluntary consent, signed under oath is not revocable unless the parent can provide clear and convincing evidence that the consent was executed by reason of fraud or duress.

(ii) In any proceeding for a voluntary TPR to an Indian child, the parent's consent may be withdrawn for any reason at any time prior to the entry of a final decree of termination. Any consent given prior to, or within 10 calendar days after the birth of the Indian child is not valid.

(B) **Abandonment.** The court may find that the parent who is entitled to custody of the child has abandoned the child.

(C) **Abandonment of an Infant.** The court may find that the child, 12 months of age or younger, was abandoned.

(D) **Non-compliance with voluntary placement agreement.** The court may find that the child's parent:

(i) voluntarily placed physical custody of the child with OKDHS or a child-placing agency for out-of-home placement;

(ii) has not complied with the placement agreement, and

(iii) has not demonstrated during the child's period of voluntary out-of-home placement a firm intent to resume physical custody of the child or make other permanent legal arrangements for the child's care.

(E) **Failure to correct conditions.** The court may find that the parent failed to correct conditions that led to the child's adjudication as a deprived child although the parent was given at least three months to correct the conditions.

(F) **Same conditions - another child.** The court may find that another child of a parent whose parental rights to any other child have been terminated and the conditions that led to the prior TPR have not been corrected.

(G) **Failure to support.** The court may find that the non-custodial parent has willfully failed, refused, or neglected to contribute to the child's support for six out of the last 12 months immediately preceding the filing of the termination petition:

(i) as specified by a court order for child support, or

(ii) according to the parent's financial ability to support the child, when an order for child support does not exist. Incidental or token support is not construed or considered when determining if the parent has maintained or contributed to the child's support.

(H) **Certain criminal convictions.** A conviction in a criminal action in any state, of any of the following acts:

(i) permitting a child to participate in pornography;

(ii) rape or rape by instrumentation;

(iii) lewd molestation of a child under 16 years of age;

(iv) child abuse or neglect;

(v) enabling child abuse or neglect;

(vi) causing the death of a child as a result of the physical or sexual abuse or chronic abuse or chronic neglect of the child;

(vii) causing the death of the child's sibling as a result of the physical or sexual abuse or chronic abuse or chronic neglect of the child's sibling;

(viii) murder of any child or aiding or abetting, attempting, conspiring, or soliciting to commit murder of any child;

(ix) voluntary manslaughter of any child;

(x) a felony assault that resulted in serious bodily injury to the child or another child of the parents; or

(xi) murder or involuntary manslaughter of the child's parent or aiding or abetting, attempting, conspiring, or soliciting to commit murder of the child's parent.

(I) **Heinous or shocking abuse.** The court may find that a parent has abused or neglected the child or child's sibling or failed to protect the child or sibling from abuse or neglect that is heinous or shocking.

(J) **Prior abuse or neglect.** The court may find that a parent has previously abused or neglected the child or child's sibling or failed to protect the child or sibling from abuse or neglect and the child or sibling has been subjected to subsequent abuse.

(K) **Rape by the parent.** The court may find the child was conceived as a result of a rape perpetrated by the parent whose rights are sought to be terminated.

(L) **Incarceration.** The parent's incarceration in and of itself is not sufficient to deprive a parent of parental rights. The court may find that the parent whose rights are sought to be terminated is incarcerated, and continuation of parental rights will result in harm to the child based on the consideration of the factors, including but not limited to:

(i) the duration of incarceration and its detrimental effect on the parent-child relationship;

(ii) previous convictions resulting in involuntary confinement in a secure facility;

(iii) history of criminal behavior, including crimes against children;

(iv) the age of the child;

(v) evidence of abuse or neglect or failure to protect the child or siblings of the child by the parent;

(vi) the current relationship between the parent and child; and

(vii) the manner in which the parent has exercised parental rights and duties in the past.

(M) **Behavioral health illness or incapacity.** The court must find that the factors in units (i) and (ii) of this subparagraph exist:

(i) the parent has a diagnosed cognitive disorder, an extreme physical incapacity, or a medical condition, including behavioral health that renders the parent incapable of adequately and appropriately exercising parental rights, duties, and responsibilities within a reasonable time, considering the age of the child; and

(ii) allowing the parent to have custody will cause the child actual harm or harm in the near future.

(I) A parent's refusal or non-compliance with treatment or assistance for the condition can be used as evidence.

(II) A finding that a parent has a diagnosed cognitive disorder, an extreme physical incapacity, or a medical condition, including behavioral health or substance dependency, does not in and of itself deprive the parent of parental rights.

(c) **Mandatory petition or motion for termination of parental rights.** Per 10A O.S. § 1-4-902, the district attorney is required to file a petition or motion to terminate the parent-child relationship and parental rights with respect to a child or joins in the petition or motion, if filed by the child's attorney when: as detailed in paragraphs (1) through (3) of this subsection.

(1) **The child is in out-of-home care for 15 out of the most recent 22 months.** Prior to the end of the fifteenth month when the child has been placed in foster care by OKDHS for 15 of the most recent 22 months. The child is considered to have entered foster care on the earlier of the date:

(A) of adjudication as a deprived child, or

(B) that is 60 calendar days after the date on which the child is removed from the home;

(2) **The child is determined to be an abandoned infant.** A petition or motion to termination parental rights is filed no later than 60 calendar days after the child is judicially determined to be an abandoned infant;

(3) **Reasonable efforts to reunite are not required due to certain felony convictions of the parent.** No later than 60 calendar days after the court has determined that reasonable efforts to reunite are not required due to a felony conviction of a parent who has:

(i) committed the murder of any child or has aided or abetted, attempted, conspired in, or solicited the commission of the murder of any child;

(ii) committed voluntary manslaughter of another child of the parent, or has aided or abetted, attempted, conspired in, or solicited the commission of voluntary manslaughter of any child; or

(iii) committed a felony assault that resulted in serious bodily injury to the child or to any child.

(d) **District attorney not mandated to file petition or motion to terminate parental rights under certain conditions.** Per 10A O.S. § 1-4-902, when any of the conditions in paragraphs (1) through (3) exist, the district attorney is not mandated to file a petition or motion for termination of parental rights.

(1) At the option of OKDHS or by order of the court, the child is properly cared for by a relative;

(2) OKDHS has documented a compelling reason for determining that filing a petition to terminate parental rights would not serve the best interests of the child that may include consideration that the:

(A) parents or legal guardians have maintained a relationship with the child and the child would benefit from continuing the relationship;

(B) child, who is 12 years of age or older objects to the termination of the parent-child legal relationship;

(C) child's foster parents are unable to adopt the child because of exceptional circumstances that do not include an unwillingness to accept legal responsibility for the child but are willing and capable of providing the child with a stable and permanent environment, and the removal of the child from the physical custody of the foster parents would be seriously detrimental to the emotional well-being of the child because the child has substantial psychological ties to the foster parents;

(D) child is not capable of achieving stability if placed in a family setting; or

(E) child is an unaccompanied, refugee minor and the situation regarding the child involves international legal issues or compelling foreign policy issues; or

(3) OKDHS has not provided to the child's family, consistent with the time period in the state case plan, services that the state deems necessary for the safe return of the child to the child's home, if reasonable efforts are required to be made with respect to the child.

(c) **Parental rights not terminated at trial.** Per 10A O.S. § 1-4-908, when parental rights are not terminated as a result of a trial, the court sets the matter for a permanency hearing within 30 calendar days. The failure of parental rights to be terminated at trial does not deprive the court of the court's jurisdiction over the child or require reunification of the child with the parent when the child is adjudicated deprived.

(d) **Adoption consent authority when parental rights terminated.** Per 10A O.S. § 1-4-907, when the court terminates parental rights and the child's custody is placed with OKDHS, the court vests OKDHS with the authority to place the child and consent to the child's adoption.

## PART 8. ~~ROLE OF THE~~ CHILD WELFARE ~~WORKER~~SPECIALIST ROLE

### 340:75-6-48.1. ~~Role~~Appointment and role of the child's attorney, guardian ad litem, and court-appointed special advocate

(a) ~~Child's~~**Appointment of child's attorney.** ~~The~~Per Section 1-4-306 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-4-306), the court may appoint an attorney ~~for~~to

represent the child when an emergency custody hearing is held~~. If a deprived petition is filed, the court~~but must appoint an attorney ~~for the child~~ to represent the child when a petition is filed alleging the child to be deprived~~in all legal proceedings in the deprived case, per Section 1-4-306 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-4-306)~~.

(1) ~~The child's attorney represents the child and any of the child's expressed interests of the child.~~ The child's attorney is independent of and not selected by the district attorney, the child's parent, legal guardian, or custodian. The parent, legal guardian, or custodian may not select the child's attorney.

(2) If financially capable, the parent, legal guardian, or custodian reimburses the ~~Court Fund~~ court fund for the services of ~~a~~the child's court-appointed attorney ~~for the child~~.

(b) ~~**Child and attorney access.** The child and the child's attorney are kept informed of each other's current location and telephone number at all times. The attorney's name, address, and telephone number are included on the Placement Provider Report in order that the child and placement provider may access the child's attorney at any time. Upon the change in placement of a custody child, the worker notifies the child's attorney with Form 04KI025E, Change in Placement Notification, as required by 10A O.S. § 1-4-804.~~

~~(c)~~ ~~**Attorney contact with child**~~**Role and responsibilities of the child's attorney.** Per 10A O.S. § 1-4-306, the child's attorney~~:appointed for the child~~

(1) represents the child and any of the child's expressed interests;

(2) arranges to meet with the child as soon as possible after receiving notification of the appointment.

(3) ~~Except~~except for good cause, ~~the attorneymust meet~~meets with the child prior to any court proceedings~~.~~;

(4) ~~The attorney may speak~~speaks with the child by telephone if a personal visit is not possible due to exigent circumstances~~.~~; and

(5) ~~If the attorney is limited in having~~contacts the custodian or caretaker of the child prior to the hearing when a meaningful attorney-client relationship ~~with~~between the child and attorney is not possible due to the child's age or ~~the child's desire~~disability, ~~the attorney contacts the custodian or caretaker of the child prior to the hearing.~~

(~~d~~c) ~~**Attorney**~~**Child attorney's access to Oklahoma Department of Human Services (OKDHS) records.** The child's attorney is entitled to access juvenile court~~,~~ and OKDHS records without a court order per 10A O.S. 1-6-103.

(~~e~~d) ~~**Attorney objection**~~**Child's attorney may object to ~~court~~court's ruling to release child from state custody.** Per 10A O.S § 1-4-801, at any hearing, including hearings where a child is to be released from state custody, the child's attorney or district attorney may give verbal notice of an objection to the court order and intention to seek review of that order based on the grounds that the order of the court releasing the child from state custody creates a serious risk of danger to the health or safety of the child. Upon receiving notice, the court issuing the custody order in question, stays the custody order pending the filing of an application and completion of review. Refer to OAC 340:75-1-16 and OAC 340:75-1-16 Instructions to Staff for additional information and guidance.

(e) **Appointment and role of the guardian ad litem or court-appointed special advocate.** For the purposes of the Oklahoma Children's Code the court-appointed special advocate and the guardian ad litem have the same function, power, duties, and responsibilities except as otherwise provided by law. After a deprived petition is filed, the court appoints a guardian ad litem upon the request of the child, child's attorney, OKDHS, another party to the action, or upon the court's own motion.

(1) The guardian ad litem is not a district attorney, an employee of the office of the district attorney, the child's attorney, an employee of the court, an employee of a juvenile bureau, or an employee of any public agency having duties or responsibilities towards the child.

(2) The guardian ad litem objectively advocates on behalf of the child and acts as an officer of the court to investigate all matters concerning the best interests of the child. In addition to other duties required or specified by the court the guardian ad litem:

(A) reviews documents, reports, records and other information relevant to the case, meets with and observes the child in appropriate settings, and interviews parents, foster parents, health care providers, child protective services workers and any other person with knowledge relevant to the case;

(B) advocates for the best interests of the child by participating in the case, attending any hearings in the matter, and advocating for appropriate services for the child when necessary;

(C) monitors the best interests of the child throughout any judicial proceeding, and

(D) presents written reports regarding the best interests of the child that include conclusions and recommendations and the facts upon which the conclusions and recommendations are based.

(3) The guardian ad litem is given access to the court and OKDHS records, each document, report, record, and other information relevant to the case and to any records and reports of examination of the child's parent or other custodian, made pursuant to the laws relating to child abuse and neglect including reports generated by service providers.

## PART 11. PERMANENCY PLANNING AND PLACEMENT SERVICES

### 340:75-6-85. Placement ~~consideration~~considerations for the child in Oklahoma Department of Human Services (OKDHS) custody

(a) **Legislative intent for ~~children~~the child placed outside the child's home.** Per 10A O.S. 1-1-102, when a child's placement outside the home is necessary, pursuant to the Oklahoma Children's Code, each child is assured the care, guidance, and supervision in a permanent home or foster home that will serve the child's best interests ~~of the child~~ including, but not

limited to, the development of the child's moral, emotional, spiritual, mental, social, educational, and physical well-being ~~of the child~~. The child is entitled to a permanent home and ~~to be placed~~placement in the least restrictive environment ~~to meet~~that meets the child's needs ~~of the child~~.

(b) **Multiethnic Placement Act of 1994.** OKDHS follows the provisions of the Multiethnic Placement Act of 1994 and the Interethnic Adoption Provisions of 1996, per OAC 340:75-1-9, unless the court finds that the Indian Child Welfare Act (ICWA) applies to the child.

(c) **OKDHS responsibility for the child's out-of-home placement.** OKDHS has the duty to provide for the care and treatment of ~~children~~each child placed in OKDHS custody by an order of the court, per Section 1-7-103 of Title 10A of the Oklahoma Statutes (10A O.S. § 1-7-103). ~~In providing care and treatment of children in OKDHS custody,~~ OKDHS:

(1) may place the child in:

(A) a kinship care home or other foster care home; or

(B) ~~if~~when no ~~such~~kinship or foster care home is available, a group home, children's shelter, or ~~in~~ any licensed facility established for the care of children~~.~~;

(2) gives priority to the child's placement ~~of the child~~ with the child's noncustodial parent ~~of the child~~ unless the placement is not in the child's best interests ~~of the child~~; and

(3) reviews and assesses ~~each~~the child to determine the type of placement and services consistent with the child's needs ~~of the child~~ in the nearest geographic proximity to the child's home ~~of the child~~ as possible.

(d) **Placement preference if not with noncustodial parent.** ~~If~~Per 10A O.S 1-7-106, when OKDHS determines that placement with the noncustodial parent is not in the child's best ~~interest~~ interests, preference is given to relatives and persons who have a kinship relationship with the child, and who are determined to be suitable, capable, and willing to serve as caretakers for the child ~~per 10A O.S 1-7-106~~. ~~OKDHS~~

(1) Per 10A O.S. § 1-4-706, every effort is made to place the child with a suitable relative of the child.

(2) OKDHS makes efforts to locate the relative, kinship relation, or resource parent who is best able to meet the child's long-term best interests. ~~OKDHS~~

(3) OKDHS reports to the court? per 10A O.S. § 1-4-204, what diligent efforts were made to secure the placement ~~per 10A O.S. § 1-4-204~~. ~~In cases where~~

(4) OKDHS complies with the ICWA ~~applies to the child, the~~ placement preferences in OAC 340:75-19-14 ~~are followed. If placement of~~when applicable to the child; and

(5) When the child cannot be ~~made~~placed pursuant to 10A O.S. 1-7-106, the reason for ~~such~~ the determination is specified in the ~~CW~~Child Welfare Services case record and provided to the court.

(e) **Court's authority to approve or disapprove placement.** When the court determines it is in the child's best interests ~~of a child~~, the court may place the child in ~~the~~OKDHS legal custody ~~of OKDHS~~. ~~Whenever~~Per 10A O.S. § 1-4-803, when the child is placed in OKDHS custody, the court may not direct OKDHS to place the child in a specific home or placement but may approve or disapprove a specific placement if it does not conform to statutory requirements and the child's best interests ~~of the child per 10A O.S. § 1-4-803~~.

(f) **~~Changing~~OKDHS authority to change the child's placement.** OKDHS has the responsibility to determine whether a placement is ~~an~~ appropriate ~~placement~~ for ~~a~~the child in OKDHS custody~~,~~ and to remove ~~a~~the child from ~~a~~the placement when ~~it is~~ in the child's best ~~interest~~interests, per 10A O.S. § 1-7-103, subject to the provisions of 10A O.S. § 1-4-804 and 1-4-805.

(g) **Placement in nearest geographic proximity to parent or school.** ~~Unless~~Per 10A O.S. § 1-4-707, unless the child is placed with relatives or in ~~accord~~accordance with ~~the~~ federal and state Indian Child Welfare Acts, ~~every effort is made to place~~ the child is placed when possible,~~within~~in the ~~county~~parent or legal guardian's district of residence ~~or if unable~~ to ~~place~~ facilitate family reunification.

(1) When an appropriate placement is not available in the parent or legal guardian's county of residence, the child is placed in an appropriate home in the nearest proximity to the ~~county~~ parent or legal guardian's district of residence ~~of the child's parent, or legal guardian~~, the child's school district, or both, to facilitate family reunification ~~of the family~~ and ensure educational consistency ~~with education~~for the child.

(2) The child's placement is not intended to correspond in frequency to ~~changes~~the parent or legal guardian's change of residence ~~of the parent or legal guardian~~. ~~In~~

(3) When determining whether the child should be moved, OKDHS considers the potential harmful effects of disrupting the child's placement ~~of the child~~ and the reason ~~of~~ the parent or legal ~~guardian's changes in residence~~guardian changed residences.

(h) **Sibling placement.** ~~Every~~Per 10A O.S. § 1-7-107, when two or more children in foster care are siblings, every reasonable attempt is made to place the siblings, who have been removed, together ~~whether~~ in the same temporary or permanent placement. ~~If separated,~~

(1) When siblings are separated, the siblings are allowed contact or visitation with each other ~~provided frequent contact or visitation~~ when appropriate.

(2) The best interests of each child determines whether joint placement, contact, or visitation is allowed. ~~If~~

(3) Per 10A O.S. § 1-4-707, when the child is a part of a sibling group, it is presumed that placement of the entire sibling group in the same placement is in the best interests of the child and siblings unless ~~thereis~~the presumption is rebutted by a preponderance of evidence to the contrary. ~~[10A O.S. § 1-7-107]~~

(i) **Indian Child Welfare Act and placement.** The federal Indian Child Welfare Act (FICWA), 25 United States Code § 1915, Oklahoma Indian Child Welfare Act (OICWA), 10 O.S. § 40.6, and OAC 340:75-19-14 define placement preferences for Indian children.

(j) **Religious consideration in placement decision.** Consideration is given to the ~~parent(s)'~~parent's wishes regarding religious preference in the selection of a placement

provider for the child, per 10A O.S. 1-4-705~~. Refer to OAC 340:75-5-49~~and OAC 340:75-6-49.

(k) **Placement stability.** ~~In order to promote stability and healthy growth of the child, it is the intent of OKDHS to limit the number of times a child is moved in out-of-home placement.~~

(1) When reunification is feasible, the child's first out-of-home placement ~~made is~~should be the best available placement to provide permanency and placement stability for the child.

(2) A request by a placement provider for immediate removal of ~~a~~the child is examined and assessed ~~regarding~~to determine whether the situation can be resolved to prevent disruption of the child's placement.

(l) **Placement provider's age.** ~~If~~Per 10A O.S. § 1-4-705, when a prospective placement provider meets the minimum age required per OAC 340:75-7-12, OKDHS may not use the age of an otherwise eligible individual as a reason for denial of placement. ~~[10A O.S. § 1-4-705]~~

(m) **Prescribed standards for placement provider.** ~~All placements~~Each placement utilized by OKDHS ~~are~~is approved or licensed by specified procedures and ~~meet~~meets prescribed standards. ~~A~~

(1) The child in ~~the~~OKDHS custody ~~of OKDHS~~ is not placed in a home, ~~whether temporary~~ temporarily or with a closely related person, prior to the ~~provider~~person meeting provider standards per OAC 340:75.

(2) ~~Placements~~Placement providers must ~~be safe,~~:

(A) provide safety for the child in OKDHS custody;

(B) have sufficient space in the home to allow the child privacy~~,~~;~~and the provider must:~~

(~~1~~C) support and participate in the child's permanency plan;

(~~2~~D) adhere to OKDHS rules, such as not using physical discipline; and

(~~3~~E) support the child's preferred religious and cultural choices.

(n) **Determining the appropriate placement.** Per 10A O.S. § 1-4-204, ~~in~~when determining the appropriate placement for ~~a~~the child, OKDHS considers, but ~~is~~does not ~~limited~~limit consideration to the:

(1) ~~the~~person's ability ~~of the person~~ to provide safety for the child, including a willingness to cooperate with any restrictions placed on contact between the child and others and to prevent others from influencing the child in regard to allegations of the case;

(2) ~~the~~person's ability ~~of the person~~ to support ~~the~~OKDHS efforts ~~of OKDHS~~ to implement the permanent plan for the child;

(3) ~~the~~person's ability ~~of the person~~ to meet the child's physical, emotional, and educational needs, including the child's need to continue in the same school or educational placement;

(4) ~~the~~ person who has the closest existing personal relationship with the child, ~~if~~when more than one person requests placement;

(5) ~~the~~person's ability ~~of the person~~ to provide a placement for the child's sibling who is also in need of placement ~~of~~or continuation in out-of-home care;

(6) ~~the~~ wishes of the parent, the relative, and the child if appropriate;

(7) ~~the~~person's ability ~~of the person~~ to care for the child as long as ~~is~~ necessary and to provide a permanent home ~~if~~when needed; and

(8) ~~the~~child's best interests ~~of the child~~.

(o) **Child's placement preference.** ~~In~~Per 10A O.S. § 1-7-110, when determining placement of a deprived child in foster care, OKDHS is governed by the child's long-term best interests ~~of the child~~. The child may express a preference as to placement and the preference may be ~~given~~expressed by the child with or without the parents, foster parents, guardians, or any other parties ~~being~~ present. OKDHS determines whether the best interests of the child are served by the child's preference~~. OKDHS~~but is not bound by the child's preference and may consider other facts in determining the placement~~, per 10A O.S. § 1-7-110~~.

(p) ~~**Bars to**~~**Certain criminal convictions prohibit placement approval.** Per 10A O.S. § 1-4-705, OKDHS does not approve prospective foster or adoptive parents as Bridge resource parents ~~if~~when the applicant, or any person residing in the prospective applicant's home, has a criminal conviction ~~record~~ for any of the felony offenses listed in paragraphs (1) through (5). The felony offenses are:

(1) physical assault, battery, or a drug-related offense within the five-year period preceding the application date;

(2) child abuse or neglect;

(3) domestic abuse;

(4) a crime against a child, including, but not limited to, child pornography; or

(5) a crime involving violence, including, but not limited to, rape, sexual assault, or homicide, but excluding those crimes specified in paragraph (A). Homicide includes manslaughter. A crime involving violence means an offense that:

(A) has as an element, the use, attempted use, or threatened use of physical force against the person or property of another; or

(B) by its nature, involves a substantial risk that physical force against the person or property of another may be used in the course of committing the offense.

(q) **Former foster parent preferred placement.** ~~A~~Per 10A O.S. § 1-9-119, the foster parent has a right to be considered as a preferred placement option when ~~a~~the foster child who was formerly placed with the foster parent reenters foster care at the same level and type of care, when the placement is consistent with the best interests of the child and other children in the foster parent's home ~~of the foster parents, per 10A O.S. 1-9-119~~.

(r) **Eligibility of foster parent to adopt the child.** Per 10A O.S. § 1-4-812, during any permanency hearing, ~~if~~when the court determines the child is to be placed for adoption and the child has resided with the foster parent for at least one year, the court considers the foster parent eligible to adopt and gives great weight to the foster parent in the adoption consideration

unless there is an existing, loving, emotional bond with a relative of the child, by blood or marriage, who is willing, able, and eligible to adopt the child.

(s) **Foster parent as essential participant.** 10A O.S. § 1-9-119 and OAC 340:75-7-37 recognize foster parents as essential participants in the decisions related to the growth, development, care, protection, and treatment of ~~a~~the child placed in ~~their~~the foster parent's home with whom they have established a familial relationship.

(t) **Foster parent rights.** A complete statement of foster parent's rights can be viewed at 10A O.S. § 1-9-119.

## SUBCHAPTER 7. FOSTER HOME CARE

## PART 4. ROLES AND RESPONSIBILITIES

**340:75-7-38. Discipline for ~~children~~the child in Oklahoma Department of Human Service (OKDHS) custody placed in foster family care**

(a) **~~Primary responsibility~~Discipline.** ~~A primary responsibility of foster families is to help children~~ "Discipline" means safe practices or methods of teaching and enforcing acceptable patterns of behavior to ensure proper conduct and does not include corporal punishment. The Bridge resource parent assists the child in OKDHS custody placed in the Bridge resource home learn behaviors that promote ~~their~~the child's self-regard, personal ability, and socialization skills. The rules governing these efforts are outlined in OAC 340:75-7-38(b) through (d).

(b) **Positive interactions.** ~~Foster~~The Bridge resource parent and family interactions with a child:

(1) protect and nurture the child's physical and psychological well-being;

(2) advance the child's development;

(3) meet the child's needs;

(4) teach the child ways to prevent and solve problems;

(5) maintain and build the parent and child relationship;

(6) build the child's self-control and responsibility; and

(7) comply with ~~Oklahoma Department of Human Services (~~OKDHS~~)~~ rules ~~on~~regarding discipline to provide a safe, nurturing environment that allows the child to experience security and positive self-esteem.

(c) **Teaching techniques.**

(1) **Positive behavior management.** Positive behavior management techniques include, but are not limited to:

(A) rewards. Rewards may be small gestures of approval, such as treats, toys, and symbols of recognition such as stickers, stars, happy faces, or money. Rewards are for the interest, desire, and effort the child displays, not for performance, talent, or ability. This technique must not be used all the time;

(B) privileges. Privileges allow the child to experience greater freedom or opportunity and an increased responsibility. Privileges are used to encourage the child's interest and talents by supporting the child's efforts in pursuing interests; and

(C) praise. Praise may be communicated ~~with a smile or nod of approval,expressing to the child how pleased the person is with him or her~~by verbal or non-verbal expression of the child's achievements or good qualities.

(2) **Self-control.** To promote the child's self-control, ~~foster parents~~The Bridge resource parent clearly ~~communicate~~communicates expectations and ~~provide~~provides a structured, safe ~~environments~~environment. The foster parent's use of planning and preparation prevents confrontation, acting-out, and negative behaviors by:

(A) establishing expectations. ~~Children~~The child in out-of-home care ~~experience~~ experiences varied expectations ~~of foster parents~~ in ~~every~~each placement setting. Since each placement setting is different, the foster parent must communicate expectations to the child~~. Expectations are communicated~~ through setting rules, telling the child what to expect, and modeling. Clearly communicated expectations provide structure for the child and a structure for building and maintaining self-control; and

(B) modifying the environment. ~~Structured~~A structured, safe ~~environments allow children~~environment allows the child to succeed at identified tasks. ~~Foster parents structure environments~~The Bridge resource parent structures the environment by removing negative sources of stimulation for the child and establishing routines and consistency in the child's day-to-day ~~schedules~~schedule.

(3) **Direct intervention.** When the child does not have sufficient self-control to ensure acceptable behavior, the ~~foster~~Bridge resource parent uses direct intervention and techniques, per OAC 340:75-7-38(c)(1) and (2). Techniques used are dependent upon the child's developmental needs and anticipated outcomes. Techniques appropriate for responding to lack of self-control include:

(A) rules. Rules are established guidelines that:

(i) allow the child to know what can and cannot be done;

(ii) help the child know right from wrong;

(iii) communicate to the child how something is done and help prevent problems; or

(iv) provide a way to respond to a problem;

(B) time out. Time out provides space between the child and a situation where the child exhibits behavior that is not acceptable or where the situation is dangerous. Recommended time out is one minute per age of the child. Time out is typically used for the younger child;

(C) restricting privileges. Privileges are restricted when a child is not allowed to do something for a specified period of time~~,~~ such as not playing with a particular toy, watching television, playing ~~the stereo~~music~~, playing~~or computer games, having phone privileges, or engaging in some other pleasant

activity. Talking to parents or siblings is not included in restricting phone privileges;

(D) grounding. Grounding involves imposing restriction on a child's interaction and involvement with friends or activities outside ~~of~~ the placement setting~~,~~ such as restriction to the house or leaving the premises to attend parties, movies, or visit friends. Grounding is typically used for the older child;

(E) logical consequences. Logical consequences require the ~~family~~Bridge resource parent to impose a response to the child's behavior consistent with and connected to the unacceptable behavior exhibited; and

(F) natural consequences. Natural consequences occur in response to the child's behavior. This technique is most appropriately used with adolescents and for ~~those~~ the child who ~~tend~~tends to get in power struggles. Natural consequences are never allowed when a child's safety or well-being is in question.

(4) **Physical discipline.** OKDHS prohibits the use of any form of physical discipline for ~~any~~ the child in OKDHS custody in an out-of-home placement or any act or omission that would emotionally, physically, or psychologically harm the child.

(A) The ~~foster~~Bridge resource parent contacts the ~~child's Child Welfare (CW) worker~~the child welfare (CW) or the resource specialist ~~if he or she~~when the Bridge resource parent cannot successfully discipline the child ~~through appropriate non-physical means~~.

(B) OKDHS and the Bridge resource parent~~does~~do not authorize ~~any~~ school personnel to administer corporal punishment to ~~any~~the child in OKDHS custody. The ~~foster~~Bridge resource parent does not ~~sign such authorizations~~, when requested, authorize corporal punishment by school personnel, but refers school personnel to the ~~child's~~ CW ~~worker~~specialist to establish alternative discipline methods.

(C) The developmental needs of ~~a~~the child and the desired outcomes define the discipline techniques used to modify the child's behaviors ~~of the child~~. Some of the circumstances that may affect the discipline technique used include:

(i) the behavior the child is exhibiting;

(ii) the foster parent's feelings about the behavior;

(iii) the purpose assigned to the behavior;

(iv) where the behavior occurs; and

(v) who is present at the time of the behavior.

(5) **Punishment.** Unacceptable behavior management methods and techniques promote negative behavior, are punitive, and do not promote self-control. Unacceptable behavior management techniques for ~~a~~the child include, but are not limited to:

(A) the use of the hand or any object, such as a board, fly swatter, paddle, belt, switch, electrical cord, hair brush, or wooden spoon, to hit, strike, swat, or physically discipline the child;

(B) deprivation of food or sleep;

(C) deprivation of family visits;

(D) slapping, pinching, shaking, biting, pushing, shoving, thumping, or rough jerking;

(E) cursing or other verbal abuse;

(F) private or public humiliation or any act that degrades;

(G) derogatory remarks about the child, the child's biological family, race, religion, or cultural background;

(H) solitary confinement in areas such as closets, cellars, and rooms with locked doors;

(I) threatening to move the child from the foster home;

(J) use of any chemical agent, such as mace, sleeping pills, or alcohol;

(K) physical force or threat of physical force;

(L) assuming and maintaining an unnatural position~~,~~ that may include holding arms out-stretched from the body, placing the nose against a wall, or forced squatting;

(M) tying with a rope, cord, or other object;

(N) ordering, allowing, or encouraging physical discipline or hitting by other children or anyone else in the home;

(O) washing the mouth out with soap, eating certain foods~~,~~ that may include peppers, ~~or~~ hot sauce, or other food stuff when intended for punishment; and

(P) forced physical exertion, such as running laps and push-ups.

(d) ~~**Physical restraint.** The use of physical restraint is only justified as an emergency safety measure in response to imminent danger to the child or others and when no alternative means are sufficient to accomplish the purpose. Physical restraint may only be used when the foster parent has been properly trained and practiced in the restraint technique demonstrated in Behavior Crisis Management Training (BCMT). The foster parent completes and submits to the child's CW worker or resource specialist Form 04FC005E, Restraint Report for Foster Family Care, when restraint is used.~~

~~(e)~~ **OKDHS rules.** The ~~foster family~~Bridge resource parent must abide by OKDHS rules ~~for~~ regarding discipline of ~~a~~the child in OKDHS custody even when there is a difference between OKDHS discipline rules and the methods used to discipline the ~~family's~~Bridge resource parent's own ~~children~~child.

## PART 25. EMERGENCY FOSTER CARE PROGRAM

### 340:75-7-262. Emergency foster care

(a) **Purpose of emergency foster care.** Emergency foster care (EFC) is short-term substitute care for ~~children~~the child in ~~the custody of~~ Oklahoma Department of Human Services (OKDHS) custody provided by a contract agency to meet the child's needs through service coordination and delivery in conjunction with OKDHS.

(b) **Admissions into EFC from certain placements or locations.**

(1) **Shelters.** The Pauline E. Mayer Shelter, Laura Dester Children's Center, and J. Roy Dunning Children's ~~shelters~~Shelter are the primary points of admission to EFC.

(A) **~~Children~~Child eligible for EFC.**

(i) ~~A~~The child younger than ~~six~~6 years of age is eligible for EFC. ~~A~~The child who reaches age ~~six~~6 while in EFC remains eligible for the service.

(ii) When it is appropriate, per OAC 340:75-6-30, and in the best interests of the child younger than ~~six~~6 years of age to have his or her sibling between the ~~ages of six~~6 through ~~nine~~9 years of age or a minor parent placed in the same placement, a plan is negotiated ~~with~~between the EFC contractor and OKDHS.

(iii) The placement of ~~a~~the child older than ~~six~~6 years of age occurs only after written approval from ~~Children and Family Services Division~~the Foster Care ~~Section~~Program Unit.

(B) **Admission into EFC from a shelter.** ~~Shelter~~OKDHS shelter staff ~~contacts~~ contacts the contract agency by phone and ~~provides~~provides available information about the child's medical, educational, social, routine, and special care needs as required to select an appropriate placement. This information is provided to the contract agency upon discharge from the shelter and includes:

(i) the shelter intake sheet with all available information;

(ii) all personal possessions;

(iii) medications and equipment;

(iv) Form ~~04FE011E~~04MP039E, Placement Provider Authorization ~~for Foster Parent Consent for Medical Services – Emergency Custody, or Form 04FE009E, Authorization for Foster Parent Consent for Medical Services~~; and

(v) Form 15GR004E, Notice of Grievance Rights - Minors in OKDHS Custody. Shelter and contract agency staff coordinate the child's admission into EFC.

(2) **~~Hospitals~~Admission into EFC from a hospital.** When ~~a~~the child is in inpatient hospital care for medical treatment ~~of medical conditions~~ related to abuse, neglect, or illness requires EFC placement, relevant background and care information is provided to the contract agency to assist ~~in~~with identifying an appropriate placement.

(A) Priority for placement into EFC is given to ~~children~~the child discharged from ~~hospitals~~a hospital.

(B) The contract agency identifies an appropriate EFC placement and coordinates the hospital discharge date, time, and any special training required with the provider and notifies OKDHS of the child's placement.

(3) **Other EFC admissions.** A child who is diverted to a non-OKDHS operated shelter or remains in current placement pending admission into EFC is placed on a waiting list maintained by the OKDHS EFC liaison. Admissions occur as beds become available.

(c) **Roles and responsibilities related to EFC.**

(1) **CW ~~worker~~specialist.** The ~~Child Welfare~~child welfare (CW) ~~worker~~specialist remains the primary connection ~~among~~between the child, ~~parent(s)~~parent, EFC agency, EFC provider, OKDHS EFC liaison, other service providers, and court while the child is in EFC. ~~The CW worker visits the child placed in EFC per OAC 340:75-6-48. At the time of admission or as soon as possible after placement, the CW worker provides the necessary information about the child to the EFC provider, including:~~

~~(A) behavioral, psychological, and social history;~~

~~(B) previous medical care;~~

~~(C) legal documentation verifying OKDHS custody status;~~

~~(D) religious affiliation; and~~

~~(E) Form 04KI004E, Placement Provider Information.~~

(2) **OKDHS EFC liaison.** The OKDHS liaison assists the EFC agency, staff, and providers in maintaining effective working relationships with OKDHS staff by providing support and consultation regarding respective roles and responsibilities.

(3) **EFC agency.** The EFC agency ensures the availability of qualified, trained staff and EFC providers 24 hours a day for the placement and care of the eligible ~~children~~child.

(A) The EFC agency coordinates with ~~the CW worker~~OKDHS to afford the child all services that promote the child's progress and ensures that the child's total care needs are met while in EFC placement.

(B) To facilitate movement of ~~children~~the child from EFC to another placement, weekly staffings occur between the CW ~~worker~~specialist and the contract agency.

(d) **Discharge from EFC.**

(1) **Notice of child's discharge from EFC.** When ~~discharge~~the child is discharged from EFC to another type of placement ~~is made~~, OKDHS provides the contract agency ~~is given~~ as much advance notice as possible, but not less than two hours.

~~(A) The CW worker notifies the contract agency of the planned move in writing, using the Client Movement Authorization Form provided by the contract agency, and coordinates the date and time for placement.~~

~~(B) The CW worker shares information to assist the EFC provider in preparing the child for the move.~~

~~(C)~~ The contract agency transports the child to the ~~county~~district office or site designated for pick-up by ~~the CW worker or staff responsible for completing the new placement~~OKDHS.

(2) **Change of placement information ~~accompanies the child~~furnished to child's new placement provider.** ~~All forms~~

(A) Each form completed by the EFC provider while the child is in EFC care:

(i) ~~assist~~assists the new provider ~~in helping~~with the ~~child adjust~~child's adjustment to the new placement~~,~~;

(ii) ~~provide~~provides information needed for continuity of care~~,~~ and;

(iii) ~~alert~~alerts the new provider of the child's special needs and strengths.

(B) ~~These~~Change of placement forms are not ~~given~~provided to the ~~parent(s)~~parent ~~if~~when the child ~~is returning~~returns home. ~~Required information~~

(C) Information and items required to be transferred from the EFC provider to the new placement provider include:

(~~A~~i) ~~all~~each of the child's medications, with instructions for dosage and use;

(~~B~~ii) equipment or supplies required for the child's special care;

(~~C~~iii) dates of any ~~follow up appointments~~appointment for the child;

(~~D~~iv) the child's personal items, unused OKDHS clothing authorizations, and clothing purchased by OKDHS, including disposable diapers;

(~~E~~v) Women, Infants and Children (WIC) vouchers, non-perishable food, and other items obtained through WIC for the child; and

(~~F~~vi) at least a 24-hour supply of formula, baby food, and other items for immediate use by the new provider.

## SUBCHAPTER 15. ADOPTIONS

## PART 10. INTEGRATED FAMILY ASSESSMENT AND PREPARATION PROCESS

### 340:75-15-87. Assessment of the prospective adoptive parent and preparation process for adoption

(a) **Bridge resource family assessment.** Pursuant to Section ~~7505-5.3~~7505-5.4 of Title 10 of the Oklahoma Statutes (10 O.S. § 7505-5.~~3~~4), the court does not require Oklahoma Department of Human Services (OKDHS) to complete resource home assessments on adoption placements made by private adoption agencies or persons providing private adoption services per 10 O.S. § 7505-5.3. OKDHS conducts an appropriate inquiry into the Bridge resource adoptive applicant and each household member's background or other circumstances and conditions to determine if the home is suitable for the child available for adoption in OKDHS custody. OKDHS assesses the prospective Bridge resource applicant's ability to parent and provide a safe environment for a child with special needs. During the assessment process the prospective Bridge resource family is provided:

(1) information about the adoption process, adoption laws, and the types of parenting issues faced by parents who adopt children with special needs; and

(2) services designed to enhance the family's ability to problem solve, access services, and cope with parenting a child with a unique history and needs.

(b) **Interviews with OKDHS adoptive applicants and household members.** The OKDHS specialist or resource assessment contractor conducts a minimum of two home visits on different dates to conduct individual and joint interviews with each Bridge resource adoptive applicant and household member.

(c) **Authorization to check OKDHS applicant's references.** The applicant grants OKDHS permission to contact the applicant's references by signing Form 04AF001E, Bridge Resource Family Assessment Application.

(d) **Physical and behavioral health and ability of OKDHS applicant to parent the child into adult years.** During the assessment process:

(1) each OKDHS Bridge resource applicant and household member submits a completed Form 04AF008E, Medical Examination Report, or other medical examination report prepared by a physician that verifies the applicant or household member's current physical health;

(2) the adoptive applicant's ability to provide care for the child into the child's adult years is assessed; and

(3) when applicable, the applicant or household member's behavioral health history is assessed.

(e) **Marriage history.** When applicable, the Bridge resource applicant verifies his or her marital history by providing copies of:

(1) a current marriage license; and

(2) any divorce decrees, legal separations, and annulment documents.

(f) **Financial statement.** The Bridge resource applicant completes Form 04AF010E, Resource Family Financial Assessment, and provides documentation of employment, income, and expenditures as a component of the assessment summary. Management of resources is more important than the family's income and is addressed in the assessment summary.

(g) **Photographs.** The Bridge resource applicant provides recent photographs of himself or herself as a component of the assessment summary.

(h) **Required pre-service training.** Pursuant to OAC 340:75-7-14, the Bridge resource applicant must complete the Oklahoma's Parent Resource for Information, Development, and Education (OKPRIDE) prescribed course of pre-service training consisting of approximately 27 hours of instruction designed to assist the applicant in evaluating the strengths, needs, and challenges associated with parenting a child with special needs.

(i) **Background checks.**

(1) **Mandate to conduct background checks.** ~~Section 7505-5.3 of Title 10 of the Oklahoma Statutes (~~Per 10 O.S. § 7505-5.3~~)mandates~~OKDHS is mandated to conduct a criminal background check and Child Abuse and Neglect Information System check for ~~all~~ each OKDHS and private adoptive resource parent ~~applicants~~applicant and household ~~members~~member 18 years of age and

older. The background check for each OKDHS ~~applicants~~applicant and adult household ~~members~~member includes a search of:

(A) Oklahoma Department of Public Safety records;

(B) Oklahoma State Bureau of Investigation (OSBI) name and criminal records history that includes the Oklahoma Sex Offender Registry;

(C) Mary Rippy Violent Offender Registry;

(D) Federal Bureau of Investigations (FBI) national criminal history records based on the applicant and each adult household member's fingerprints;

(E) the applicant or adult household member's involvement as a party in any court action found on:

(i) Oklahoma State Courts Network (OSCN); or

(ii) Oklahoma District Court Records (ODCR);

(F) Child Abuse and Neglect Information System (CANIS) for history of child maltreatment involving the applicant or any adult household member;

(G) a Family Advocacy background check for ~~all~~each active or retired military ~~families~~family; and

(H) ~~all~~each applicable out-of-state child abuse and neglect ~~registries~~registry when ~~an~~the applicant or adult household member has not lived continuously in Oklahoma for the past five years.

(i) When no child abuse and neglect registry is maintained in the applicable state, the adoption specialist requests any information that can be provided.

(ii) The prospective adoptive parent is not approved without the results of the state-maintained child abuse and neglect registry check when a registry is maintained in the applicable state.

(I) Juvenile Justice Information System (JOLTS) records for each child 13 years of age and older residing in the applicant's household.

(2) **CANIS and the private adoptive applicant.** The private adoptive applicant, adoption agency, or other person authorized to conduct home study investigations:

(A) completes a written request for a CANIS search via Form 04AN028E, Request for Child Abuse and Neglect Information System Search; and

(B) submits the form, with verification of impending adoption, to the ~~CFSD~~ Child Protective Services ~~Section~~Program Unit at P.O. Box 25352, Oklahoma City, Oklahoma 73125-9975.

(3) **Fingerprint-based background search.** A national criminal history records search based upon submission of fingerprints is required for the OKDHS Bridge resource applicant and household ~~members~~member 18 years of age and older.

(A) When a fingerprint-based search has been conducted within the past five years and is reviewed by OKDHS, only an OSBI criminal background check is required.

(B) A home study is not initiated when any applicant or adult household member refuses to sign or submit Form 04AD003E, Request for Background Check.

(i) ~~All~~Each adult household ~~members~~member 18 years of age and older ~~complete~~completes and ~~sign~~signs Form 04AD003E and ~~submit~~submits fingerprint cards authorizing OKDHS to conduct a records check.

(ii) Background information that reveals a risk to ~~the~~a child is a basis for denying the application, per OAC 340:75-15-88.

(4) **Exception to fingerprinting.** Pursuant to 10A O.S. § 1-7-111, the OKDHS Director or designee may authorize an exception to the fingerprinting requirement for prospective OKDHS and private adoptive applicants and adult household members 18 years of age and older, and authorize use of an alternative procedure for obtaining a national criminal records check for any applicant or adult residing in the home who has a severe condition that precludes such person being fingerprinted. The alternative procedure may be used in limited, and case-specific circumstances when OKDHS may not be able to obtain:

(A) ~~an~~the individual's fingerprints as a result of the individual's disability; or

(B) legible fingerprints due to low quality fingerprints, as a result of age, occupation, or otherwise thereby making it impossible for the national crime information databases (NCID) to provide the results.

(5) **Approval of Bridge resource applicant.** OKDHS may approve ~~a~~the Bridge resource applicant for adoption when the applicant and the home meet the foster home and adoption program eligibility standards, per OAC 340:75-7-19.

*[OAR Docket #13-897; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES DIVISION

*[OAR Docket #13-894]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Administration
Part 1. General Administration
340:100-3-5.1 [AMENDED]
**(Reference WF 12-08)**
**AUTHORITY:**
Director for Human Services; Section 162 of Title 56 of the Oklahoma Statutes (56 O.S. § 162); 10 O.S. § 1415; 10 O.S. § 1430.1 et seq.; 51 O.S. § 151 et seq.; 63 O.S. § 1-1901 et seq.; and The Domestic Volunteer Service Act (DVSA) of 1973, Public Law (P.L.) 93-113.
**DATES:**
**Comment period:**
January 2, 2013 through February 1, 2013
**Public hearing:**
None requested

**Adoption:**
March 18, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
The proposed amendments to Chapter 100 Subchapter 3 amend the rules to: (1) designate Developmental Disabilities Services Division (DDSD) State Office staff that have authority to approve and deny volunteer guardianship exceptions and limit volunteer guardians to serving no more than two service recipients without an exception; (2) clarify requirements for background checks; (3) designate DDSD State Office staff that have authority to approve or revoke medication administration training (MAT); (4) remove the requirement that agencies submit the MAT training records to DDSD; and (5) no longer require staff Social Security numbers on training records.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 3. ADMINISTRATION

## PART 1. GENERAL ADMINISTRATION

### 340:100-3-5.1. Volunteer guardians and advocates

(a) **Purpose.** Developmental Disabilities Services Division (DDSD) contracts with an agency to maintain a system to recruit, screen, match, monitor, and support volunteer guardians and advocates for eligible service recipients. To be eligible, the service recipient must:

(1) be assigned a DDSD case manager;

(2) have been determined through the capacity assessment process, per OAC 340:100-3-5, to need a guardian or volunteer advocate; and

(3) if volunteer guardianship is recommended; have no appropriate relative willing to serve as guardian.

(b) **~~Responsibilities of~~ DDSD responsibilities.**

(1) When the need for a guardian or advocate ~~has been~~is determined through the capacity assessment process, per OAC 340:100-3-5, the DDSD case manager forwards Form 06MP032E, Capacity Assessment, with a recommendation for a volunteer guardian or advocate to the DDSD case management supervisor. If volunteer guardianship is recommended, documentation of attempts made to locate a guardian, among those who are eligible per OAC 340:100-3-5~~,~~ must be included.

(2) The DDSD case management supervisor reviews the documents, and if approved, forwards the documents to the guardianship coordinator.

(3) The guardianship coordinator reviews Form 06MP032E and, if approved, makes a referral to the volunteer guardianship agency to initiate the process to recruit a volunteer guardian or advocate.

(c) **Volunteer guardianship eligibility requirements.** In addition to requirements per OAC 340:100-3-5, eligibility criteria for volunteer guardians listed in subsections (1) through (6) apply.

(1) A corporate officer, member of the board of directors, owner, operator, administrator, or employee of a facility subject to provisions of Section 1-1901 et seq. of Title 63 of the Oklahoma Statutes (63 O.S. § 1-1901 et seq.) or 10 O.S. § 1430.1 et seq., or ~~any~~ other DDSD ~~provider is~~providers are ineligible to be appointed volunteer guardian of a person receiving services from that provider ~~agency or provider~~.

(A) An immediate family member, spouse, parent, sibling, or adult child, of an ineligible person cannot serve as a volunteer guardian.

(B) An extended family member of an ineligible person cannot serve as a volunteer guardian when there is evidence that financial interdependence exists.

(2) Employees of DDSD cannot serve as volunteer guardians.

(A) An immediate family member, spouse, parent, sibling, or adult child, of the DDSD employee cannot serve as a volunteer guardian, ~~if~~when the employee is a member of the service recipient's Personal Support Team (Team).

(B) An extended family member of the DDSD employee cannot serve as a volunteer guardian when there is evidence that financial interdependence exists, and the employee is a member of the service recipient's Team.

(3) Any exceptions to the selection of a volunteer guardian, per OAC 340:100-3-5.1(c)(1) and (2) must be approved by the DDSD ~~director or designee~~programs manager for guardianship.

(4) Employees of Oklahoma Department of Human Services (OKDHS) cannot serve as volunteer guardians for residents of Northern Oklahoma Resource Center of Enid (NORCE), Southern Oklahoma Resource Center (SORC), or Robert M. Greer Center (Greer), per 10 O.S. § 1415.

(5) Potential guardians must:

(A) ~~pass~~consent to a background check per OAC 340:100-3-39 and OKDHS Community Services Worker Registry check;

(B) ~~possess the willingness and ability to devote time and energy to serve as guardian~~ be willing and able to fulfill guardian responsibilities;

(C) be certified by the volunteer guardianship agency; and

(D) approved by the Team.

(6) A volunteer guardian:

(A) supports ~~the philosophy~~philosophies and values consistent with the DDSD mission statement per OAC 340:100-1-3.1; and

(B) ~~serves no more than two wards~~may not act as a volunteer advocate or guardian for more than two service recipients unless approved in advance and in writing by the ~~DDSD director or designee~~DDSD programs manager for guardianship.

(d) **Volunteer advocate eligibility requirements.** DDSD supports the recruitment of volunteers from outside the service delivery system to avoid potential conflicts of interest.

(1) Non-DDSD OKDHS employees, contract providers, and employees of contract providers may serve as volunteer advocates when:

(A) an ongoing relationship exists with the service recipient; and

(B) they are not providing direct services to the service recipient and are not employed by a provider agency or OKDHS division that provides services to the service recipient; and

(C) they serve as a volunteer advocate or guardian for no more than two service recipients.

(2) DDSD employees may not serve as volunteer advocates.

(3) Any exceptions to the selection of a volunteer advocate, per OAC 340:100-3-5.1 must be approved in advance and in writing by the DDSD ~~director or designee~~programs manager for guardianship.

(e) **~~Responsibilities of a volunteer~~Volunteer guardian responsibilities.** ~~The responsibilities of a volunteer~~Volunteer guardian responsibilities are outlined ~~in~~per OAC 340:100-3-5.

(f) **~~Responsibilities of a volunteer~~Volunteer advocate responsibilities.** A volunteer advocate assists the service recipient in making decisions and supports the service recipient in preserving his or her rights and obtaining necessary services. Such support may include:

(1) advocating for the service recipient;

(2) assisting the service recipient in decision making;

(3) reviewing the quality of services provided to the service recipient;

(4) attending the Individual Plan (IP) meeting or other meeting(s);

(5) assisting the service recipient with finances;

(6) accompanying the service recipient to medical appointments; or

(7) assisting the service recipient in completing applications.

(g) **~~Responsibilities of a temporary volunteer~~Volunteer advocate responsibilities.** ~~The assistance of a temporary~~Temporary advocate assistance is requested when a service recipient or Team seeks a guardianship dismissal in order to restore full decision making rights to the service recipient. ~~The responsibilities of a temporary~~Temporary volunteer advocate responsibilities include:

(1) filing a petition on behalf of the service recipient as an interested party so the request for restoration of capacity can be heard in court; and

(2) after capacity is restored, continuing to be available to the service recipient for support and guidance for a period of no more than six months.

(h) **Guardianship voucher.** ~~The~~After the volunteer guardianship agency certifies a prospective volunteer guardian the action is approved by Team approval, and if able, the service recipient. The volunteer ~~applies for and receives~~submits Form 06MP031E, Guardianship Voucher, per OAC 340:100-3-5.2, to pay the attorney ~~fee~~fees necessary to file the guardianship petition ~~after certification by the volunteer guardianship agency, and approval by the Team and, if able, the service recipient~~. Court involvement is not required to establish volunteer advocacy, therefore the voucher is not available in such cases.

(i) **~~Monitoring of volunteer guardians and advocates~~Volunteer guardian and advocate monitoring.** ~~Monitoring of the volunteer guardians and advocates~~Volunteer guardian and advocate monitoring is provided by the volunteer guardianship agency ~~according to~~per requirements ~~specified~~ in the OKDHS and agency contract ~~with the agency~~.

(j) **~~Training~~Volunteer guardian and advocate training requirements ~~for volunteer guardians and advocates~~.** Volunteers must participate in training regarding understanding and defining advocacy, developing effective advocacy skills, working effectively with service recipients and Teams, community inclusion, Oklahoma's service delivery system, and confidentiality. Volunteer guardians must participate in additional training regarding guardianship responsibilities, duties, and limitations.

(1) Training is provided by the volunteer guardianship agency at no cost to the volunteer.

(2) Volunteers receive orientation from volunteer guardianship agency regarding applicable OKDHS rules and procedures regarding volunteer programs.

(3) Volunteer guardians proceed with knowledge they are not covered by 51 O.S. § 151 et seq., The Governmental Tort Claims Act, as they are not authorized to act on behalf of OKDHS, nor can they be so authorized without creating a conflict of interest in their roles as guardians.

(k) **~~Responsibilities of volunteer~~Volunteer guardianship agency responsibilities.** ~~Duties of the volunteer~~Volunteer guardianship agency responsibilities include:

(1) recruiting volunteers to serve as guardians and advocates;

(2) obtaining background checks of potential volunteer guardians and advocates;

(3) contacting references. The volunteer guardianship agency contacts a minimum of three references. If responses are negative or if three references cannot be found, the volunteer is not considered;

(4) submitting proposed volunteers to the Personal Support Team for review and approval;

(5) arranging visits between potential volunteers and service recipients;
(6) providing training and orientation on OKDHS rules and procedures, including 51 O.S. § 151 et seq.;
(7) monitoring ~~in accordance with~~per OAC 340:100-3-5.1; and
(8) providing technical assistance as requested by the volunteer or DDSD case manager, including:
(A) attending any team meetings;
(B) accompanying the volunteer on home visits;
(C) reviewing legal or specific documents or records regarding the service recipient; and
(D) providing due date reminders ~~of due dates~~ for annual court reports, and ~~if~~when needed, providing assistance ~~to complete the~~completing reports.

*[OAR Docket #13-894; filed 5-22-13]*

## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 110. LICENSING SERVICES

*[OAR Docket #13-895]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
Part 1. Licensing Services - Child Care
340:110-1-4.1 [AMENDED]
340:110-1-9.2 through 340:110-1-9.3 [AMENDED]
Part 3. Licensing Services - Residential Care and Agencies
340:110-1-43.1 [AMENDED]
340:110-1-47.1 through 340:110-1-47.2 [AMENDED]
**(Reference WF 12-24)**
**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes (56 O.S. § 162); and the Child Care Facility Licensing Act, 10 O.S. § 401.
**DATES:**
**Comment period:**
February 1, 2013 through March 4, 2013
**Public hearing:**
None requested
**Adoption:**
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March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
n/a
**INCORPORATIONS BY REFERENCE:**
n/a

**ANALYSIS:**
The proposed amendments to Chapter 110, Subchapter 1 amend the rules to: (1) clarify division policy and practice; and (2) assist with the consistent enforcement of licensing requirements as it relates to the use of a form to be completed by facilities when addressing non-compliances with licensing requirements.
**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 1. GENERAL PROVISIONS

### PART 1. LICENSING SERVICES - CHILD CARE

**340:110-1-4.1. Forms**

Forms that apply to this Part are described in this Section.
(1) **07LC002T, Staff Summary.** Form 07LC002T is used to document compliance with licensing requirements for all staff currently employed by the child care facility.
(2) **07LC003E, Monitoring Report - Child Care Center.** Form 07LC003E is used by ~~the~~ licensing staff to document compliance with requirements during a monitoring visit at a child care center and record any other information obtained.
(3) **07LC004E, Request for License - Child Care Facility.** Form 07LC004E is used to request a license to operate a child care facility, including a child care center, school-age program, and part-day children's program.
(4) **07LC005E, Transportation Information.** Form 07LC005E is used by a child care facility director to document compliance with licensing requirements on transportation.
(5) **07LC006E, Equipment Inventory - Child Care Center.** Form 07LC006E is used to document the equipment available and items needed to comply with OKDHS Publication no. 84-08, Licensing Requirements for Child Care Centers.
(6) **07LC007E, Training Documentation.** Form 07LC007E is used by child care facilities to document annual training of staff.
(7) **07LC008E, Periodic Monitoring Report - Certification for Care of Children with Disabilities.** Form 07LC008E is used by ~~the~~ licensing staff to document ongoing compliance with certification requirements during monitoring visits.
(8) **07LC010E, Monitoring Report - Part-Day Children's Program.** Form 07LC010E is used by ~~the~~ licensing staff to document compliance with licensing requirements during a monitoring visit at a part-day children's program and to record any other information obtained.

(9) **07LC012E, Licensing Complaint.** Form 07LC012E is used to record a complaint against a child care facility.

(10) **07LC014E, Monitoring Report - Family Child Care Home.** Form 07LC014E is used to document compliance with requirements during a monitoring visit to a family child care home and record other information obtained.

(11) **07LC020E, Equipment Inventory - Part-Day Children's Program.** Form 07LC020E is used to document the equipment available or needed to comply with Licensing Requirements for Part-Day Children's Programs, no. 95-12, OKDHS Publication.

(12) **07LC021E, Comments and Recommendations Regarding Licensing Requirements.** Form 07LC021E is used to make comments and recommendations pertaining to licensing requirements and policy.

(13) **07LC023E, Monitoring Report - School-Age Program.** Form 07LC023E is used to document compliance with licensing requirements for school-age programs during a monitoring visit and record any other information obtained.

(14) **07LC024E, Equipment Inventory - School-Age Program.** Form 07LC024E is used to document the equipment available or needed to comply with Licensing Requirements for School-Age Programs, no. 97-10, OKDHS Publication.

(15) **07LC025E, Request for Child Care Center Star Certification.** Form 07LC025E is used by a child care center owner or director to request star certification.

(16) **07LC026E, Child Care Center Star Certification Review.** Form 07LC026E is used to document compliance with criteria for star certification and to establish a plan to correct violations in a child care center.

(17) **07LC027E, Request for Family Child Care Home Star Certification.** Form 07LC027E is used by a family child care home provider to request star certification.

(18) **07LC028E, Family Child Care Home Star Certification Review.** Form 07LC028E is used to document ongoing compliance with criteria for star certification and to establish a plan to correct violations in a family child care home.

(19) **07LC037E, Notice to Comply.** Form 07LC037E is used by a child care facility to document ~~a plan~~required plans of correction ~~when there is serious or repeated non-compliance with licensing requirements~~.

(20) **07LC038E, Child Information.** Form 07LC038E is used by the child care facility to record enrollment information for a child.

(21) **07LC041E, Staff Information - Child Care Facility.** Form 07LC041E is used to record information regarding child care facility staff persons as required by licensing requirements.

(22) **07LC042E, Request for License - Family Child Care Home and Large Child Care Home.** Form 07LC042E is used to make application for license to operate a family child care home or large child care home.

(23) **07LC057E, Physical Plant.** Form 07LC057E is used by licensing staff to document the floor plan, including indoor and outdoor square footage and numbers of toilets and sinks.

(24) **07LC061E, Alternative Compliance Request.** Form 07LC061E is used by a child care facility to request an alternative method of complying with licensing requirements.

(25) **07LC068E, Licensing Specialist Training Checklist.** Form 07LC068E is used by licensing staff to ensure completion of all training requirements, per policy, for new licensing specialists.

(26) **07LC069E, Compliance Review for Child Care Centers.** Form 07LC069E is used by child care center directors to verify their knowledge of the licensing requirements.

(27) **07LC070E, Fire Safety Inspection Report for Child Care.** Form 07LC070E is used by fire officials for inspection of facilities.

(28) **07LC071E, Licensing Services Waiver Referral.** Form 07LC071E is used by licensing staff when submitting a waiver request to State Office.

(29) **07LC072E, Compliance Review for School-Age Programs and Summer Day Camps.** Form 07LC072E is used by school-age and summer day camp directors to verify their knowledge of the licensing requirements.

(30) **07LC073E, Compliance Review for Part-Day Children's Programs.** Form 07LC073E is used by part-day children's program directors to verify their knowledge of the licensing requirements.

(31) **07LC074E, Request for Extension of Time to Comply.** Form 07LC074E is used by child care providers to request an extension of time to comply with Stars criteria.

(32) **07LC075E, Notice of Alternative Compliance.** Form 07LC075E is used by licensing staff to notify a facility of an approved request for alternative method of compliance.

(33) **07LC079E, Child Death Report.** Form 07LC079E is used by licensing staff in the event of a child death in a child care facility.

(34) **07LC080E, Licensing Services Supplemental Information.** Form 07LC080E is used to provide supplemental facility information.

(35) **07LC081E, Licensing Complaint Report Summary.** Form 07LC081E is placed in the case record and includes the findings of an investigation in compliance with Section 406 of Title 10 of the Oklahoma Statutes.

(36) **07LC084E, Notice to Parents.** Form 07LC084E is posted in child care facilities to inform parents of the requirements for licensing compliance posting and the licensing compliance file.

(37) **07LC085E, Notice of Voluntary Cease Care.** Form 07LC085E is used to verify with facilities their agreement to voluntary cease care.

(38) **07LC086E, Staff Information - Family Child Care Home.** Form 07LC086E is used to record information regarding family child care home staff persons as required by licensing requirements.
(39) **07LC087E, Waiver Notification.** Form 07LC087E is used to inform facilities of a decision regarding a waiver request.
(40) **07LC088E, Notice of Emergency Order.** Form 07LC088E is used to notify parents of an immediate closure of their child care facility.
(41) **07LC089E, Child Care Waiver Request.** Form 07LC89E is used by a program director to request a waiver for ~~persons~~a person with a restricted criminal history.
(42) **07LC090E, Waiver Reference.** Form 07LC090E is used to obtain references for ~~persons~~a person with a restricted criminal history.
(43) **07LC091E, Change of Ownership.** Form 07LC091E is used by current and prospective owners of facilities to notify licensing of ownership changes.
(44) **07LC092E, Insurance Verification.** Form 07LC092E is completed annually to verify liability insurance coverage.
(45) **07LC093E, Insurance Exception Notification.** Form 07LC093E is completed and posted at the facility to notify parents that liability insurance coverage is not provided or facility reports they are self-insured.
(46) **07LC095E, Notice Regarding Unlicensed Care.** Form 07LC095E is provided to facilities during the investigation of unlicensed care.
(47) **07LC096E, Criminal History Review Request.** Form 07LC096E is completed by facilities to request a criminal history review by licensing records office.
(48) **07LC097E, Citation Request.** Form 07LC097E is used when requesting assistance of Council on Law Enforcement Education and Training (CLEET)-certified officers.
(49) **07LC098E, District Attorney Referral.** Form 07LC098E is used when requesting a district attorney file criminal charges and/or issue an injunction.
(50) **07LC099E, Dual Approval Request for Kinship Placement in a Licensed Family Child Care Home.** Form 07LC099E is used for approving acceptance of a foster care placement in a family child care home.
(51) **07LC100E, Emergency Order Request.** Form 07LC100E is used by licensing specialist and supervisor when requesting an emergency order.
(52) **07LC101E**, **Restricted Registry Verification.** Form 07LC101E is used by child care facilities and licensing to verify non-registration and registration of individuals recorded on the Child Care Restricted Registry.
(53) **07LC102E, Restricted Registry Notification.** Form 07LC102E is used by the licensing records office to notify individuals of potential registration on the Child Care Restricted Registry.
(54) **07LC103E, Restricted Registry Final Notification.** Form 07LC103E is used by licensing records office to notify individuals of registration on the Child Care Restricted Registry.
(55) **07LC104E, Restricted Registry Notification to Child Care Facility.** Form 07LC104E is used by the licensing records office to notify child care facilities of ~~registration of~~ individuals registered on the Child Care Restricted Registry.
(56) **Form 07LC105E**, **Alternative Compliance Referral.** Form 07LC105E, is used by licensing staff to refer an alternative compliance request to State Office personnel.
(57) **Form 07LC106E, Criminal History Review Results.** Form 07LC106E is used to notify facilities of the results of the criminal history review.
(58) **Form 07LC107E, Child Care Restricted Registry Notice.** Form 07LC107E is used as additional notification to facility employees and residents of the Child Care Restricted Registry registration process.

**340:110-1-9.2. Complaint investigations**

(a) **Legal basis.** The Child Care Facilities Licensing Act (Act) [10 O.S. § 406] mandates ~~that~~ the Oklahoma Department of Human Services (OKDHS) conduct a full investigation of a complaint alleging a violation against the Act or any licensing requirement.
(b) **Receipt of the complaint.** Complaints may be made to licensing in writing, in person, by telephone, or electronically.
(c) **Complaint information.** ~~The licensing~~Licensing staff obtains as much relevant information as possible from the complainant.
(d) **Screening complaints.** ~~The licensing~~Licensing staff accepts a complaint for investigation when it alleges:
(1) non-compliance with licensing requirements;
(2) operation of an unlicensed facility in violation of the Act; or
(3) abuse or neglect of a child in care.
(e) **Complaint risk levels.** Risk levels are determined by ~~the~~ licensing staff based upon the degree of harm or danger to children in care. Risk levels are used to ensure that investigations occur in a timely manner and to track types of complaints.
(1) **Risk level I complaints.** Risk level I complaints indicate a child is in imminent risk of serious physical harm. The level of risk is not influenced by the removal of a child from the facility if other children remain in care. Investigations are initiated immediately or no later than 24 hours after receipt of the complaint by ~~the~~ licensing staff unless awaiting investigation by Child Welfare Services~~(CW)~~(CWS) or law enforcement. This does not include weekends and holidays ~~if~~when the facility is closed. Examples of risk level I complaints include:
(A) alleged physical or sexual abuse;
(B) presence or use of illegal drugs while children are in care;
(C) distribution of drugs;
(D) children left alone in the facility or in a vehicle;
(E) extreme facility temperatures;
(F) an infant placed on the stomach for sleeping;
(G) threatening or impaired behavior of a caregiver;
(H) severe understaffing or over licensed capacity;
(I) unlicensed facility;

(J) violating an Emergency Order;

(K) required staff without current cardio-pulmonary resuscitation and first aid training;

(L) failure to obtain background investigations; or

(M) knowingly permitting access to children by persons identified as restricted or registrants.

(2) **Risk level II complaints.** Risk level II complaints do not indicate there is imminent risk of harm, but without intervention, a child may not be safe. Investigations are initiated within 15 calendar days of receipt of the complaint by ~~the~~ licensing staff, or sooner depending on the degree of risk, unless advised by ~~CW~~CWS or law enforcement to delay the investigation. Examples include:

(A) leaving children with an underage staff person;

(B) alleged physical abuse from a staff person no longer working in the facility;

(C) inappropriate discipline where no injury is reported;

(D) broken playground equipment;

(E) injury caused by lack of supervision; or

(F) minor understaffing.

(3) **Risk level III complaints.** Risk level III complaints do not indicate imminent risk of harm and there are no injuries alleged. Investigations are initiated within 30 calendar days of the date of receipt of the complaint by ~~the~~ licensing staff or immediately if a telephone investigation is appropriate. Examples include:

(A) inadequate meal service;

(B) lack of play equipment;

(C) inappropriate use of television or videos; or

(D) inadequate cleanliness of the facility.

(f) **The investigation.** ~~The licensing~~Licensing staff conducts a full investigation, obtaining sufficient information to make a finding.

(g) **Telephone investigation.** With supervisory approval, ~~the~~ licensing staff may investigate a complaint by telephone. The discussion and, if necessary, an agreed-upon plan of correction, is documented on Form 07LC080E, Licensing Services Supplemental Information. A copy is sent to the operator. A complaint may be investigated by telephone only when:

(1) the alleged non-compliance does not place children at risk of harm, for example, the facility did not serve milk one day or children have head lice;

(2) the facility has not had numerous, repeated, or serious non-compliance; and

(3) a monitoring visit has been made in the last three months during which substantial compliance was documented.

(h) **Procedure for investigating an allegation of operating an unlicensed facility.** When a complaint alleging operation of an unlicensed facility is received, the procedure ~~contained in~~per OAC 340:110-1-13 is also followed.

(i) **Child abuse and neglect complaints.** Upon receipt of a complaint alleging abuse or neglect of a child in care, ~~the~~ licensing staff immediately notifies the licensing supervisor and makes a referral to ~~CW~~CWS. If the allegation involves child abuse or neglect or a report indicating that a child is in imminent risk of serious physical harm, the licensing regional programs manager is also notified.

(j) **Findings.** After the investigation is completed, the licensing staff, in consultation with the licensing supervisor, as appropriate, makes a finding as to whether the complaint is substantiated, unsubstantiated, or ruled out.

(1) **Substantiated.** A finding of substantiated is made when a weighing of the information obtained during the investigation clearly indicates the facility violated any licensing requirement or the Act.

(2) **Unsubstantiated.** A finding of unsubstantiated is made when the information does not lead to a definite conclusion, for example:

(A) there is insufficient or conflicting information on which to conclude that a violation occurred; or

(B) information needed to make a finding is unavailable.

(3) **Ruled out.** A finding of ruled out is made when a weighing of the information clearly indicates that there was not a violation of any licensing requirement or the Act.

(k) **Documentation of findings.** Upon completion of the investigation, ~~the~~ licensing staff:

(1) documents the findings;

(2) notifies the provider of the complaint allegations and findings by sending a complaint findings cover letter, Form 07LC081E, Licensing Complaint Report Summary, and if applicable, Form 04CP004E, Child Welfare Investigative Summary Notification to Child Care Licensing Services;

(3) enters the complaint information on the licensing database using complaint key words; and

(4) updates and closes the complaint tracking screen.

(l) **Use of Notice to Comply.** When a ~~serious~~ complaint allegation has been substantiated, ~~the~~ licensing staff advises the facility to correct the violations immediately and requests ~~that~~ the facility complete Form 07LC037E, Notice to Comply, following the procedure in OAC 340:110-1-9.3(d)(7).

(m) **Summary of facts.** Facility owners, directors, or primary caregivers may submit a written request for a summary of the facts used to evaluate and determine the licensing complaint findings.

(n) **Complaint overview.** Licensing staff complete an overview of completed complaint investigations on Form 07LC080E. This overview provides a summary of the investigation, how the complaint findings were determined, and is filed in the confidential section.

**340:110-1-9.3. Non-compliance with requirements**

(a) **Documentation of non-compliance.** ~~The Oklahoma Child Care Services (OCCS) licensing~~ Licensing staff documents clearly and concisely ~~documents on the monitoring report~~ areas of non-compliance and the discussion with the operator on the monitoring report.

(1) A plan of correction, including a specific agreed-upon time period for correction of the non-compliance, is documented for each non-compliance on the monitoring report. If a previous non-compliance was not

corrected by the agreed-upon time period, the non-compliance is documented again with a shorter plan of correction date.

(2) Immediate correction is required when the non-compliance has a direct impact on the ~~heath~~health, safety, or well-being of one or more children in care.

(3) ~~The licensing~~Licensing staff requests ~~that~~ the operator sign the monitoring report, and explains ~~that~~ the operator's signature indicates acknowledgment of information recorded.

(4) If the person in charge refuses to sign, the refusal is documented on the report.

(5) The operator is given a copy of the completed monitoring report.

(b) **Referrals to fire and health officials.** If non-compliance regarding fire or health requirements places children at risk or remains uncorrected, ~~the~~ licensing staff requests an inspection by a fire, health, or Department of Environmental Quality official. If there is non-compliance regarding smoke detectors, the child care provider is given a copy of the Smoke Detector Law, Section 324.11A of Title 74 of the Oklahoma Statutes. If the non-compliance is not corrected by the third monitoring visit or is frequently repeated, copies of the monitoring reports are sent with a cover letter to the appropriate fire official for enforcement of the law.

(c) **Numerous, repeated, and serious non-compliance.**

(1) Numerous non-compliance is any monitoring visit with:

(A) five or more items documented as non-compliant on the monitoring report for a family child care home or large child care home;

(B) six or more items documented as non-compliant on the monitoring report for a child care center, part-day children's program, or school-age program with a licensed capacity of less than 60; or

(C) seven or more items for a child care center, part-day children's program, or school-age program with a licensed capacity of 60 or more.

(2) Repeated non-compliance is three or more documented incidents of non-compliance with the same requirement within the last 12 months. For missing immunizations to be considered a repeat non-compliance, they must be regarding the same child.

(3) Serious non-compliance is a non-compliance with licensing requirements that exposes children to conditions that present an imminent risk of harm. Imminent risk of harm must be assessed based on the age of the child, the amount of time the caregiver was out of compliance, and the caregiver's efforts to mitigate the risk. Serious non-compliances are identified through licensing observations, confirmed complaint investigations, and/or self-reported incidences. Some examples of non-compliance that may be considered as serious are:

(A) staff-child ratio;

(B) supervision of children;

(C) infant sleep environments;

(D) prohibited disciplinary actions;

(E) licensed capacity;

(F) use of passenger restraints;

(G) water activities;

(H) pools and other water hazards;

(I) multiple hazards;

(J) weapons;

(K) reporting child abuse;

(L) knowingly permitting access to children by persons identified as restricted or registrants;

(M) failure to obtain background investigations or Child Care Restricted Registry searches;

(N) administering medication to children;

(O) room temperatures;

(P) heat sources and loss of any utility service;

(Q) compliance file and or posting;

(R) cardio-pulmonary resuscitation and first aid training;

(S) liability insurance; and

(T) vehicle liability insurance.

(d) **Case management responses to non-compliant facilities.** When there is numerous, repeated, or serious non-compliance, one or more of the actions in (1) through ~~(11)~~(12) is taken.

(1) **Technical assistance.** Technical assistance is offered along with referrals to consultants or training resources, if necessary, to assist the operator in meeting and maintaining licensing requirements.

(2) **Follow-up phone call.** Follow-up phone calls are made, and documented on Form 07LC080E, Licensing Services Supplemental Information. A copy of the documentation is mailed to the facility.

(3) **Non-compliance letters.** A non-compliance letter may be written to the operator. A copy of the non-compliance letter is sent to the owner or registered agent, if applicable, with a copy of the monitoring report.

(4) **Return monitoring visit.** A return monitoring visit may be made if there is numerous, repeated, or serious non-compliance with licensing requirements or when non-compliance places children at imminent risk of harm. If the non-compliance is associated with a specific time of day, such as understaffing after school or a lack of early morning supervision, the return visit is made at that approximate time.

(5) **Use of witnesses.** ~~The licensing~~Licensing staff may be accompanied by a witness during monitoring visits if the facility has had numerous, repeated, or serious non-compliances or if denial or revocation of the license is under consideration. The witness may be an Oklahoma Department of Human Services (OKDHS) employee or a representative from the health or fire department. The witness signs the monitoring report in the space provided.

(6) **Increased monitoring visits.** Licensing staff may increase the frequency of monitoring when there has been numerous, repeated, or serious non-compliance or when the need for additional technical assistance is indicated.

(7) **Notice to comply.** ~~The licensing~~Licensing staff provides the facility with Form 07LC037E, Notice to Comply, on which the facility documents the plan of correction. Immediate correction may be required if the

non-compliance places the health, safety, or well-being of one or more children in care at risk.

(A) If the plan submitted by the operator is unacceptable to ~~the~~ licensing staff, ~~the~~ licensing staff negotiates and documents a revised plan.

(B) If ~~the Notice to Comply~~Form 07LC037E is not submitted within the specified time period, ~~the~~ licensing staff contacts the operator and documents the conversation.

(C) ~~If concerns exist or the owner is uncooperative the~~When non-compliances continue to place children at risk, licensing staff sends a letter stating ~~that failure to complete a Notice to Comply~~the non-compliances and/or continued failure to correct non-compliances may result in revocation of license, denial of the application, filing of an injunction, or Emergency Order.

(8) **Office conference.** ~~The licensing~~Licensing staff may schedule an office conference with the owner of the facility. The licensing supervisor is present at the office conference. The licensing regional programs manager (RPM) is informed of the office conference and may be present, if necessary.

(A) Areas of non-compliance and progress toward meeting the plan(s) of correction are reviewed and technical assistance is offered.

(B) The conference is documented on Form 07LC080E, which is signed by ~~the~~ licensing staff, the operator, and any witnesses present. This documentation includes a list of every person who is present, the purpose of the conference, and verification of correct documentation regarding ownership.

(C) ~~A Notice to Comply~~Form 07LC037E is completed if one addressing these issues has not been completed recently.

(9) **Consent agreement.** OKDHS and the ~~owner of the~~ facility owner may enter into a consent agreement whereby the facility owner agrees to specific conditions in lieu of license denial or revocation, per OAC 340:110-1-9.5.

(10) **Revocation.** ~~The licensing~~Licensing staff may recommend ~~that~~ the application to become licensed be denied or the license be revoked when numerous, repeated, or serious non-compliance with requirements has been observed and documented or the facility ~~has~~ failed to adequately protect children, per OAC 340:110-1-10.

(11) **Voluntary cease care.** With State Office approval, the owner is asked to voluntarily cease caring for children. The RPM is notified of ~~all situations~~every situation involving a request for voluntary cease care.

(12) **Voluntary closure.** With State Office approval, the owner is asked to voluntarily close the facility, per OAC 340:110-1-11.

(e) **Case management responses when children are at risk.** ~~If the~~When licensing staff documents non-compliance with requirements or is investigating a complaint that may place the health, safety, or well-being of children at imminent risk of harm, options to consider during consultation with the operator and ~~the~~ licensing supervisor are outlined in this subsection.

(1) The operator is asked to immediately correct the non-compliance, for example, the staff person will not work at the facility pending the outcome of an investigation.

(2) The owner is asked to discontinue child care until the non-compliance is corrected or the investigation is complete.

(3) The owner is asked to voluntarily close the facility.

(4) ~~The licensing~~Licensing staff requests an Emergency Order, per OAC 340:110-1-9.4, when immediate action is needed to protect children in a child care facility.

(5) The owner agrees to enter into a consent agreement whereby the facility owner agrees to specific conditions in lieu of license denial or revocation, per OAC 340:110-1-9.5.

(6) ~~The licensing~~Licensing staff may recommend ~~that~~ the application be denied or license be revoked when numerous, repeated, or serious non-compliance with requirements ~~has been~~ was observed and documented or the facility ~~has~~ failed to adequately protect children, per OAC 340:110-1-10.

(7) An injunction may be requested when a child care facility is:

(A) unlicensed;

(B) on application status;

(C) licensed;

(D) violating an Emergency Order;

(E) operating during an appeal following revocation or denial and children are at risk; or

(F) violating the notice to cease care following revocation or denial of license.

(f) **Notification to supervisor when children are at risk.** If during a monitoring visit ~~the~~ licensing staff is concerned ~~that~~ the health, safety, or well-being of children is at imminent risk, the licensing supervisor or OCCS State Office staff is contacted immediately for an appropriate response.

(g) **Alternative method of compliance.** OCCS may approve an alternative method of compliance to a minimum licensing requirement. An alternative method of compliance may be authorized if licensing determines ~~that~~ the alternative method of compliance offers equal protection of health, safety, and well-being to children, meets the basic intent of the requirements for which the alternative compliance was requested, and does not violate statutory requirements.

(1) An applicant or licensee may submit a written request with any supporting documentation on Form 07LC061E, Alternative Compliance Request, to the licensing specialist. A separate request is submitted for each requirement for which an alternative method of compliance is requested.

(2) Licensing specialist completes Form 07LC105E, Alternative Compliance Referral, and submits all documentation to the statewide licensing coordinator or designee for authorization.

(3) Approval of an alternative method of compliance does not set a precedent, and is independently evaluated on the merits of each request.

(4) The facility's record of compliance is taken into consideration in determining whether to approve the request.

(5) An alternative method of compliance is not authorized for critical items affecting the health and safety of a child, such as exceeding licensed capacity or staff-child ratios, fire safety violations, or behavior and guidance violations.

(6) Written notice from OCCS, Form 07LC075E, Notice of Alternative Compliance, stating the nature of the exception, is posted with the license.

## PART 3. LICENSING SERVICES - RESIDENTIAL CARE AND AGENCIES

### 340:110-1-43.1. Forms

Forms that apply to this Part are listed in this Subsection.

(1) **07LC005E, Transportation Information.** Form 07LC005E is used by a child care facility director to document compliance with licensing requirements on transportation.

(2) **07LC012E, Licensing Complaint.** Form 07LC012E is used by licensing staff to record a complaint against a child care facility.

(3) **07LC016E, Recommendation for Licensing or Certification of a Child Care Center.** Form 07LC016E is used by licensing staff and supervisors to make recommendations on the licensing or certification of child care facilities.

(4) **07LC021E, Comments and Recommendations Regarding Licensing Requirements.** Form 07LC021E is used to make comments and recommendations pertaining to licensing requirements and policy.

(5) ~~**07LC022E, Child Placing Agency - Foster Care File Review.** Form 07LC022E is used by licensing staff to record the agency's compliance or non-compliance with licensing requirements for foster home care.~~

~~(6)~~ **07LC037E, Notice to Comply.** Form 07LC037E is used by a facility to document ~~a plan~~ required plans of correction ~~when there is serious or repeated non-compliance with licensing requirements~~.

(~~7~~6) **07LC039E, Child Care Staff Health Record.** Form 07LC039E is used to document tuberculosis testing and also used by an examining physician to document an employee's physical exam.

(~~8~~7) **07LC040E, Request for License - Child-Placing Agency, Residential Child Care, and Children's Shelter.** Form 07LC040E is used by an agency or residential facility to request application for a child care facility license.

(~~9~~8) **07LC041E, Staff Information - Child Care Facility.** Form 07LC041E is used to record required information regarding child care facility staff.

(~~10~~9) **07LC043E, Child Placing Agency Compliance Review.** Form 07LC043E is used by licensing staff to assess compliance with child-placing agency requirements.

~~(11)~~ ~~**07LC044E, Adoption Services File Review.** Form 07LC044E is used by licensing staff to record the agency's compliance or non-compliance with licensing requirements for placement of children for adoption.~~

(~~12~~10) **07LC047E, Agency Certification Report.** Form 07LC047E is completed by ~~the~~ child-placing agency staff to certify to the Oklahoma Department of Human Services that each foster home or ~~Independent Living~~independent living arrangement complies with the Licensing Requirements for Child-Placing Agencies.

(~~13~~11) **07LC050E, Personnel File Review - Agency and Residential Programs.** Form 07LC050E is used by licensing staff to document compliance with personnel record requirements in residential and child-placing agency requirements.

(~~14~~12) **07LC056E, Compliance Review-Residential Child Care Facility.** Form 07LC056E is used by licensing staff to assess compliance with residential requirements.

(~~15~~13) **07LC058E, Monitoring Report-Residential Child Care Facility.** Form 07LC058E is used by licensing staff to document compliance with requirements during a visit to a residential facility and record any other information obtained.

(~~16~~14) **07LC059E, Residential Child Care Facility - Resident File Review.** Form 07LC059E is used by licensing staff as part of the licensing process to document compliance with residential facility requirements.

(~~17~~15) **07LC060E, Residential Child Care Policy and Records Check.** Form 07LC060E is used by licensing staff to document compliance with residential policy and procedure requirements.

(~~18~~16) **07LC065E, Resident Monitoring Report.** Form 07LC065E is used by licensing staff to record the agency's compliance with independent living program licensing requirements ~~for independent living programs~~.

(~~19~~17) **07LC071E, Licensing Services Waiver Referral.** Form 07LC071E is used by licensing staff when submitting a waiver request to State Office.

(~~20~~18) **07LC078E, Child-Placing Agency - Record of Foster Home Closure.** Form 07LC078E is used by a child-placing agency to report a foster home closure ~~of a foster home~~.

(~~21~~19) **07LC079E, Child Death Report.** Form 07LC079E is completed by licensing staff to record the death of a child while in child care.

(~~22~~20) **07LC080E, Licensing Services Supplemental Information.** Form 07LC080E is used when additional space for documentation is needed, when a complete monitoring report is not required, to document office and telephone contacts, and to record other information for the licensing record.

(~~23~~21) **07LC081E, Licensing Complaint Report Summary.** Form 07LC081E is placed in the case record

and includes the findings of the investigation in compliance with Section 406 of Title 10 of the Oklahoma Statutes.

(~~24~~22) **07LC087E, Waiver Notification.** Form 07LC087E is used to inform facilities of a decision regarding a waiver request.

(~~25~~23) **07LC089E, Child Care Waiver Request.** Form 07LC89E is used by a program director to request a waiver for ~~persons~~a person with a restricted criminal history.

(~~26~~24) **07LC090E, Waiver Reference.** Form 07LC090E is used to obtain references for ~~persons~~a person with a restricted criminal history.

(~~27~~25) **07LC092E, Insurance Verification.** Form 07LC092E is completed annually to verify liability insurance coverage.

(~~28~~26) **07LC095E, Notice Regarding Unlicensed Care.** Form 07LC095E is provided to facilities during the investigation of unlicensed care.

(~~29~~27) **07LC096E, Criminal History Review Request.** Form 07LC096E is completed by facilities to request a criminal history review by licensing records office.

(~~30~~28) **07LC097E, Citation Request.** Form 07LC097E is used when requesting assistance of Council on Law Enforcement Education and Training (CLEET)-certified officers.

(~~31~~29) **07LC098E, District Attorney Referral.** Form 07LC098E is used when requesting a ~~DA~~district attorney file criminal charges and/or issue an injunction.

(~~32~~30) **07LC101E**, **Restricted Registry Verification.** Form 07LC101E is used by child care facilities and licensing to verify non-registration and registration of individuals recorded on the Child Care Restricted Registry.

(~~33~~31) **07LC102E, Restricted Registry Notification.** Form 07LC102E is used by the licensing records office to notify individuals of potential registration on the Child Care Restricted Registry.

(~~34~~32) **07LC103E, Restricted Registry Final Notification.** Form 07LC103E is used by licensing records office to notify individuals of registration on the Child Care Restricted Registry.

(~~35~~33) **07LC104E, Restricted Registry Notification to Child Care Facility.** Form 07LC104E is used by the licensing records office to notify child care facilities of ~~registration of~~ individuals registered on the Child Care Restricted Registry.

(~~36~~34) **07LC106E, Criminal History Review Results.** Form 07LC106E is used to notify facilities of the results of the criminal history review.

(~~37~~35) **Form 07LC107E, Child Care Restricted Registry Notice.** Form 07LC107E is used as additional notification to facility employees of the Child Care Restricted Registry registration process.

(36) **Form 07LC108E, Monitoring Report - Child Placing Agencies.** Form 07LC108E is used by licensing staff to document compliance with licensing requirements during a monitoring visit to a child placing agency and to record other information obtained.

(37) **Form 07LC110E, Child Placing Agency - Policy and Records Check.** Form 07LC110E is used by licensing staff to document compliance with child placing agency policy and procedure requirements.

**340:110-1-47.1. Complaint investigations**

(a) **Legal basis.** The Child Care Facilities Licensing Act (Act), ~~Sections 401 et seq. of Title 10 of the Oklahoma Statutes~~[10 O.S. § 406], mandates ~~that~~ the Oklahoma Department of Human Services (OKDHS) conduct a full investigation of a complaint alleging a violation against the Act or any licensing requirement.

(b) **Receipt of the complaint.** Complaints may be made to Licensing Services, in writing, in person, by telephone, or electronically.

(c) **Complaint information.** ~~The licensing~~Licensing staff obtains as much relevant information as possible from the complainant.

(d) **Screening complaints.** ~~The licensing~~Licensing staff accepts a complaint for investigation when it alleges:

(1) non-compliance with licensing requirements;

(2) operation of an unlicensed facility in violation of the Act; or

(3) abuse or neglect of a child in care.

(e) **Disposition of complaints.** Upon receipt of a complaint, ~~the~~ licensing staff determines a disposition, as described in this subsection.

(1) A complaint that does not meet the criteria in (d) is discussed with the complainant, and, ~~if~~when appropriate, a referral is made to another entity, such as law enforcement, the Office of Juvenile Affairs, Office of Client Advocacy (OCA), ~~OKDHS Children and Family Services Division~~Child Welfare Services, or ~~OKDHS~~ Office for Civil Rights.

(2) A complaint alleging violation of licensing requirements or operation of an unlicensed facility is investigated by Licensing Services.

(3) A complaint alleging child abuse or neglect is immediately referred to OCA with a copy of Form 07LC012E, Licensing Complaint. ~~If~~When an immediate response to the referral is not received, ~~the~~ licensing staff follows up the next ~~working~~business day to obtain a response.

(4) When a complaint alleges commission of a crime, including illegal drug activity in the child care facility, it is immediately referred to Office of Inspector General (OIG) and local law enforcement where the facility is located.

(A) ~~The referral is followed up~~Referral follow ups are documented in writing; a copy is filed in the facility record; and the programs manager is notified.

(B) It is the responsibility of ~~the~~ licensing staff to follow up with local law enforcement officials to determine and document the outcome of the investigation.

(C) A referral to OIG is documented on Form 19MP001E, Referral Form.

(5) A complaint received from another division within OKDHS or an agency responsible for monitoring residential child care facilities or child-placing agencies, such as the Oklahoma Commission on Children and Youth (OCCY), OCA, or the local health or fire department, is deemed valid ~~if~~when documented in writing by the agency representative. Licensing staff determines whether the observation is a non-compliance. The facility is advised of the report and given an opportunity to respond.

(6) The programs manager is notified of any complaint:

(A) in which the alleged non-compliance caused or could cause imminent risk of harm to a child in care;

(B) when the facility has numerous, repeated, or serious non-compliance with requirements;

(C) when the alleged non-compliance ~~has been~~was addressed in a previous Form 07LC037E, Notice to Comply;

(D) ~~that was~~ referred to OCA or law enforcement; or

(E) ~~that is~~ receiving special attention, such as from the media or a legislator.

(f) **Complaint risk levels.** Risk levels are determined by ~~the~~ licensing staff based upon the degree of harm or danger to children in care. Risk levels are used to ensure that investigations occur in a timely manner and to track types of complaints.

(1) **Risk level I complaints.** Risk level I complaints indicate a child is in imminent danger of serious physical injury. The level of risk is not influenced by the removal of a child from the facility if other children remain in care. Investigations are initiated immediately or no later than 24 hours after receipt of the complaint by ~~the~~ licensing staff unless awaiting investigation by OCA or law enforcement. Examples of risk level I complaints include:

(A) alleged physical or sexual abuse;

(B) presence or use of illegal drugs while children are in care;

(C) distribution of drugs;

(D) children left alone in the facility or in a vehicle;

(E) extreme facility temperatures;

(F) an infant placed on the stomach for sleeping;

(G) threatening or impaired behavior of a caregiver;

(H) severe understaffing or over licensed capacity;

(I) unlicensed facility;

(J) violating an Emergency Order;

(K) required staff without current cardio-pulmonary resuscitation and first aid training;

(L) failure to obtain background investigations; or

(M) knowingly permitting access to children by persons identified as restricted or registrants.

(2) **Risk level II complaints.** Risk level II complaints do not indicate there is imminent danger of injury, but without intervention a child may not be safe. Investigations are initiated within 15 calendar days of receipt of the complaint by ~~the~~ licensing staff, or sooner, depending on the degree of risk, unless advised by OCA or law enforcement to delay the investigation. Examples of risk level II complaints include:

(A) leaving children with an underage staff person;

(B) alleged physical abuse from a staff person no longer working in the facility;

(C) inappropriate discipline where no injury is reported;

(D) broken playground equipment;

(E) injury caused by lack of supervision; or

(F) minor understaffing.

(3) **Risk level III complaints.** Risk level III complaints do not indicate imminent danger and there are no injuries alleged. Investigations are initiated within 30 calendar days of the date of receipt of the complaint by ~~the~~ licensing staff or immediately if a telephone investigation is appropriate. Examples of risk level III complaints include:

(A) inadequate meal service;

(B) inappropriate use of television or videos; or

(C) inadequate cleanliness of the facility.

(g) **The investigation.** ~~The licensing~~Licensing staff conducts a full investigation, obtaining sufficient information to make a finding.

(h) **Telephone investigation.** With supervisory approval, ~~the~~ licensing staff may investigate a complaint by telephone. The discussion and, ~~if~~ when necessary, an agreed-upon plan of correction ~~is~~are documented on Form 07LC080E, Licensing Services Supplemental Information. A copy is sent to the operator. A complaint may be investigated by telephone only ~~if~~when:

(1) the alleged non-compliance does not place children at risk of harm, for example, the facility did not serve milk one day or children have head lice;

(2) the facility has not had numerous, repeated, or serious non-compliance; and

(3) a monitoring visit has been made in the last three months during which substantial compliance was documented.

(i) **Procedure for investigating allegations of operating an unlicensed facility.** When allegations of operating an unlicensed facility are investigated, ~~the~~ procedures ~~contained in~~per OAC 340:110-1-54.1 are also followed.

(j) **Child abuse and neglect complaints.** Upon receipt of a complaint alleging abuse or neglect of a child in care, ~~the~~ licensing staff immediately notifies the programs manager and makes a referral to the Office of Client Advocacy.

(k) **Findings.** After the investigation is completed, ~~the~~ licensing staff, in consultation with the programs manager, as appropriate, makes a finding as to whether the complaint is substantiated, unsubstantiated, or ruled out.

(1) **Substantiated.** A finding of substantiated is made when a weighing of the information obtained during the investigation clearly indicates ~~that~~ the facility violated a licensing requirement or the Act.

(2) **Unsubstantiated.** A finding of unsubstantiated is made when the information does not lead to a definite conclusion, for example:

(A) there is insufficient or conflicting information on which to conclude ~~that~~ a violation occurred; or

(B) information required to make a finding is unavailable.

(3) **Ruled out.** A finding of ruled out is made when a weighing of the information clearly indicates there was not a violation of a licensing requirement or the Act.

(l) **Documentation of findings.** Upon completion of the investigation, ~~the~~ licensing staff documents the complaint allegations, findings, notifies the provider in writing, and enters the complaint information on the licensing database using complaint key words.

(m) **Notice to Comply.** When a ~~serious~~ complaint allegation is substantiated, ~~the~~ licensing staff advises the facility to correct the violations immediately, using Form 07LC037E, Notice to Comply, following procedure per OAC 340:110-1-47.2(c)(7). The facility must complete a plan of correction.

(n) **Summary of facts.** Facility or agency owners or program directors may submit a written request for a summary of the facts used to evaluate and determine the licensing complaint findings.

(o) **Complaint overview.** Licensing staff ~~provide~~complete an overview of completed complaint investigations on Form 07LC080E. This overview provides a summary~~overview~~ of the investigation, how the complaint findings were determined, and is filed in the confidential section.

**340:110-1-47.2. Non-compliance with requirements**

(a) **Documentation of non-compliance.** ~~The licensing~~Licensing staff documents clearly and concisely ~~on the monitoring report~~ areas of non-compliance and the discussion with the operator on the monitoring report.

(1) A plan of correction, including an agreed-upon time period for correction of the non-compliance, is documented on the monitoring report for each non-compliance or documentation indicates a plan of correction will be submitted by the executive or program director. If a previous non-compliance was not corrected by the agreed-upon time period, the non-compliance is documented again with a shorter plan of correction date.

(2) Immediate correction is required when the non-compliance has a direct impact on the health, safety, or well-being of a child(ren) in care.

(3) ~~The licensing~~Licensing staff requests that the operator sign the monitoring report, explaining ~~that~~ the operator's signature indicates acknowledgment of information recorded.

(4) ~~If~~When the person in charge refuses to sign, the refusal is documented on the report.

(5) The operator is given a copy of the completed monitoring report.

(b) **Referrals to fire and health officials.** ~~If~~When non-compliance regarding fire or health requirements places children at risk of harm or remains uncorrected, ~~the~~ licensing staff requests an inspection by a fire, health, or Oklahoma Department of Environmental Quality (ODEQ) official.

(c) **Case management responses to non-compliant facilities.** The responses in this subsection may be used when there is repeated, numerous, or serious non-compliance.

(1) **Technical assistance.** Technical assistance is offered along with referrals to consultants or training resources, ~~if~~when necessary, to assist the operator in meeting and maintaining licensing requirements.

(2) **Follow-up phone call.** Phone calls are documented on Form 07LC080E, Licensing Services Supplemental Information, and a copy is mailed to the facility.

(3) **Non-compliance letter.** A non-compliance letter may be written to the operator. ~~The licensing~~Licensing staff sends a copy of the monitoring report and non-compliance letter to the governing board or owner, ~~if~~when applicable.

(4) **Return monitoring visit.** A return monitoring visit may be made if there is repeated, numerous, or serious non-compliance with licensing requirements or when non-compliance places children at imminent risk of harm. If the non-compliance is associated with a specific time of day, such as understaffing after school or a lack of early morning supervision, the return visit is made at that approximate time.

(5) **Use of witnesses.** ~~The licensing~~Licensing staff may be accompanied by a witness during monitoring visits if the facility has had numerous, repeated, or serious non-compliances or if license denial or revocation ~~of the license~~ is being considered. The witness may be an Oklahoma Department of Human Services (OKDHS) employee or a representative from the health or fire department. The witness signs the monitoring report in the space provided.

(6) **Increased monitoring visits.** Licensing staff may increase the frequency of monitoring when there has been numerous, repeated, or serious non-compliance or when the need for additional technical assistance is indicated.

(7) **Notice to comply.** ~~The licensing~~ Licensing staff provides the facility with Form 07LC037E, Notice to Comply, on which the facility documents the plan of correction. Immediate correction may be required ~~if~~when the non-compliance places the health, safety, or well-being of a child(ren) in care at risk.

(A) ~~If~~when the plan submitted by the operator is unacceptable to ~~the~~ licensing staff, the staff negotiates and documents a revised plan.

(B) If the operator does not submit ~~the response to~~ Form 07LC037E within the specified time period, ~~the~~ licensing staff contacts the operator and documents the conversation. ~~If concerns exist or the owner is uncooperative, the licensing staff sends a letter stating that failure to complete Form 07LC037E may result in revocation of license, denial of the application, the filing of an injunction, or Emergency Order.~~

(C) When non-compliances continue to place children at risk, licensing staff sends a letter stating non-compliances and/or continued failure to correct non-compliances may result in revocation of license, denial of the application, filing of an injunction, or Emergency Order.

(8) **Office conference.** ~~The licensing~~Licensing staff may schedule an office conference with the owner of the

facility. The programs manager is present at the office conference. Areas of non-compliance and progress toward meeting the plan(s) of correction are reviewed and technical assistance is offered. The conference is documented on Form 07LC080E~~, which is~~and signed by ~~the~~ licensing staff, the operator, and ~~any~~ witnesses present. This documentation includes a list of the persons present, ~~the~~ purpose of the conference, and verification of correct documentation regarding ownership. Form 07LC037E is completed if one addressing these issues has not been completed recently.

(9) **Consent agreement.** OKDHS and ~~the owner of~~ the facility owner may enter into a consent agreement whereby the facility owner agrees to specific conditions in lieu of license denial or revocation.

(10) **Revocation.** ~~The licensing~~Licensing staff ~~recommends that~~may recommend the application for licensure be denied or the license revoked when numerous, repeated, or serious non-compliance with requirements has been observed and documented or the facility ~~has~~ failed to adequately protect children.

(11) **Voluntary cease care.** With State Office approval, the owner is asked to voluntarily cease caring for children. The programs manager is notified of ~~all situations~~every situation involving a request for voluntary cease care.

(12) **Voluntary closure.** The owner is asked to voluntarily close the facility.

(d) **Case management responses when children are at risk.** ~~If the~~When licensing staff documents non-compliance with requirements or is investigating a complaint that children may be at imminent risk of harm, options to consider during consultation with the operator and the programs manager are outlined in this subsection.

(1) The operator is asked to immediately correct the non-compliance; for example, the staff person will not work at the facility pending the outcome of an investigation.

(2) The owner is asked to voluntarily close the facility.

(3) ~~The licensing~~Licensing staff requests an Emergency Order when immediate action is needed to protect children in a child care facility that is on permit, licensed, on notice of revocation or denial, or operating during an appeal following revocation or denial.

(4) The owner agrees to enter into a consent agreement whereby the facility owner agrees to specific conditions in lieu of license denial or revocation.

(5) ~~The licensing~~Licensing staff ~~recommends that~~may recommend the license be denied or revoked when numerous, repeated, or serious non-compliance with requirements ~~has been~~ was observed and documented or the facility ~~has~~ failed to adequately protect children.

(6) An injunction may be requested when the residential facility or child-placing agency is:

(A) unlicensed;

(B) on application status;

(C) licensed;

(D) violating an Emergency Order;

(E) operating during an appeal following revocation or denial and children are at risk of harm; or

(F) violating the notice to cease care following denial or revocation of license.

*[OAR Docket #13-895; filed 5-22-13]*

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## TITLE 340. DEPARTMENT OF HUMAN SERVICES
## CHAPTER 110. LICENSING SERVICES

*[OAR Docket #13-896]*

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 3. Licensing Standards for Child Care Facilities
Part 1. Requirements for Child Care Centers
340:110-3-14 [AMENDED]
Part 2. ~~Requirement~~Requirements for Part-Day Children's Programs
340:110-3-45 [AMENDED]
Part 5. Requirements for Family Child Care Homes and Large Family Child Care Homes
340:110-3-91.1 [AMENDED]
Part 9. Requirements for Residential Child Care Facilities
340:110-3-157 [AMENDED]
**(Reference WF 12-26)**

**AUTHORITY:**
Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes; Child Care Facility Licensing Act, Section 401 and 404 of Title 10 of the Oklahoma Statutes; and Section 104(b) of the Consumer Product Safety Improvement Act of 2008, and Sections 1219 and 1220 of Title 16 of The Code of Federal Regulations.

**DATES:**
**Comment period:**
February 1, 2013 through March 4, 2013
**Public hearing:**
None requested
**Adoption:**
March 18, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rule(s) resulted in approval on May 17, 2013.
**Final adoption:**
May 17, 2013
**Effective:**
November 1, 2013

**SUPERSEDED EMERGENCY ACTIONS:**
n/a

**INCORPORATIONS BY REFERENCE:**
n/a

**ANALYSIS:**
The proposed amendments to Chapter 110, Subchapter 3 amend the rules to: (1) comply with Section 104(b) of the Consumer Product Safety Improvement Act of 2008 that requires the United States Consumer Product Safety Commission to promulgate consumer product safety standards for durable infant or toddler products; and (2) ensure any crib provided by child care facilities and family child care homes meets new and improved federal safety standards set forth by Consumer Product Safety Commission per Sections 1219 and 1220 of Title 16 of The Code of Federal Regulations (16 CFR §§ 1219 and 1220) for full-size and non-full size cribs.

**CONTACT PERSON:**
Dena Thayer, Programs Administrator, Policy Management Unit, OKDHS, P.O. Box 25352, Oklahoma City, OK 73125, 405-521-4326.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF NOVEMBER 1, 2013:**

## SUBCHAPTER 3. LICENSING STANDARDS FOR CHILD CARE FACILITIES

## PART 1. REQUIREMENTS FOR CHILD CARE CENTERS

**340:110-3-14. Indoor equipment**

(a) **General.** The equipment required in this subsection assists the caregiver in providing for each child's physical, cognitive, emotional, and social development.

(1) A variety of equipment is accessible to all children on a daily basis and can be rotated for children's use.

(2) Equipment is:

(A) complete, sturdy, and in good working condition;

(B) maintained in a safe and sanitary condition;

(C) lead free, as in crayons and paint;

(D) of appropriate size and type to meet the developmental needs of the age group; and

(E) provided in quantities proportionate to the number of children in each age group and the number of children for which the center is licensed.

(3) Sleeping equipment and bedding complies with the requirements in OAC 340:110-3-25.5.

(4) Indoor climbing equipment over four feet high has impact-absorbing mats in fall zones that extend a minimum of six feet in all directions from the perimeter of the equipment.

(5) Caregivers monitor play equipment for potential hazards, for example, splinters, loose parts, and sharp edges.

(6) Toys or objects with removable parts with a diameter less than 1-1/4 ~~inch~~inches, toys with sharp points or edges, toys with strings, plastic bags, ~~styrofoam~~Styrofoam? objects, and rubber balloons are not accessible to children younger than three years of age.

(7) Infant walkers are prohibited.

(8) The director constantly reevaluates equipment as enrollment varies. When the number of children in an age group increases, additional equipment is provided in accordance with the ratios and developmental levels of the children in care ~~contained in the requirements in~~ per OAC 340:110-3-14(b) through (g) requirements.

(b) **Minimum equipment for infants.** When infants are in care, the requirements listed in this subsection are met.

(1) Basic items required are:

(A) one crib, port-a-crib, or playpen with a mattress or playpen pad for each child up to ten months of age. Mats or cots may be used for children ten months of age and older;

(B) fitted crib sheets, one per child;

(C) diaper-changing table;

(D) adult-height shelf;

(E) individual, adult-size chair for each caregiver;

(F) separate, individual space for personal belongings;

(G) adequate ~~container~~containers with tight-fitting ~~lid~~lids or moisture-proof bags for soiled or wet diapers or clothing;

(H) adequate supply of diapers, facial tissue, disposable wipes, bath towels, and wash cloths;

(I) extra supply of sheets; and

(J) sufficient clothing in various sizes in case of accidents.

(2) Cribs meet the requirements for safety contained in (A) through ~~(D)~~(C) of this paragraph.

(A) ~~Cribs, port-a-cribs, and playpens do not have more than 2 and 3/8 inches between slats and between the side and end panels.~~Cribs, including portable cribs that can be folded or collapsed without being disassembled, meet the current Consumer Product Safety Commission (CPSC) full-size and non-full size crib standards per Sections 1219 and 1220 of Title 16 of the Code of Federal Regulations.

(B) ~~Decorative cutout areas in crib end panels or decorative knobs on the corner posts, which can entrap a child's head or catch his or her clothing, are prohibited.~~Verification of compliance with CPSC standards is maintained for duration of crib use.

(C) Mattresses and playpen pads are firm and fit the crib, port-a-crib, or playpen snugly with no more than one inch between the mattress and crib.

~~(D) Drop side latches hold sides securely and are not accessible by the child in the crib.~~

(3) Mattresses and ~~play pen~~playpen pads are covered with a durable, washable, waterproof, form-fitting material.

(4) Mesh-sided cribs and playpens must meet the conditions in (A) through (E) of this paragraph.

(A) Mesh is less than $\frac{1}{4}$ inch in size, smaller than the buttons on a baby's clothing.

(B) Mesh has no tears, holes, or loose threads that could entangle a child.

(C) Mesh is securely attached to the top rail and floor plate.

(D) The top rail cover has no tears or holes.

(E) If staples are used, they are not missing, loose, or exposed.

(5) Additional equipment is provided ~~in accordance with~~per OKDHS Appendix L-5, Child Care Center Minimum Indoor Equipment Requirements.

(c) **Minimum equipment for toddlers.** When toddlers are in care, the requirements listed in this subsection are met.

(1) Basic items required are:

(A) one crib or playpen with a mattress, mat, or cot per child;
(B) table space with a chair for each child;
(C) baskets or low open shelves for toy storage;
(D) separate individual space for personal belongings;
(E) adult-height shelf;
(F) diaper-changing table;
(G) adequate ~~container(s)~~containers with tight-fitting ~~lid(s)~~lids or moisture-proof bags for soiled or wet diapers or clothing;
(H) sheet and cover, one of each per child;
(I) adequate supply of diapers, facial tissue, disposable wipes, bath towels, and wash cloths~~, bath towels, facial tissue, and disposable wipes~~;
(J) extra supply of sheets and covers; and
(K) sufficient clothing in various sizes in case of accidents.

(2) Cribs meet the requirements for safety ~~listed in~~per OAC 340:110-3-14(b)(2).

(3) Mattresses and playpen pads are covered with a durable, washable, waterproof, form-fitting material.

(4) Additional equipment is provided ~~in accordance with~~per OKDHS Appendix L-5.

(d) **Minimum equipment for ~~two-year-olds~~children 2 years of age.** When ~~two-year-old~~ children 2 years of age are in care the requirements listed in this subsection are met.

(1) Basic items required are:
(A) one cot, bed, or mat per child;
(B) table space with a chair for each child;
(C) separate, individual space for personal belongings;
(D) baskets or low open shelves for toy storage;
(E) adequate ~~container~~containers with tight-fitting ~~lid~~lids or moisture-proof bags for soiled or wet diapers or clothing;
(F) sheet and cover, one per child;
(G) extra supply of sheets and covers;
(H) adequate supply of diapers, facial tissue, disposable wipes, bath towels, and wash cloths~~, bath towels, facial tissue, and disposable wipes~~;
(I) sufficient clothing in various sizes in case of accidents and
(J) a place to go, for example, a barrel, tented area, playhouse, or designated quiet area.

(2) Additional equipment is provided ~~in accordance with~~per OKDHS Appendix L-5.

(e) **Minimum equipment for ~~three-year-olds~~children 3 years of age.** When ~~three-year-old~~ children 3 years of age are in care the equipment requirements listed in this subsection are met.

(1) Basic items required are:
(A) one cot, bed, or mat per child;
(B) separate individual space for personal belongings;
(C) table space with a chair for each child;
(D) two linear feet of low open shelves per child in each room for play equipment;
(E) sheet and cover, one per child;
(F) extra supply of sheets and covers;
(G) adequate supply of facial tissue, bath towels, wash cloths, and soap~~, and towels~~;
(H) sufficient clothing in various sizes in case of accidents; and
(I) a place to go, for example, a barrel, tented area, playhouse, ~~bean-bag~~beanbag chair, or designated quiet area.

(2) Additional equipment is provided in accordance with OKDHS Appendix L-5.

(f) **Minimum equipment for ~~four- and five-year-olds~~children 4 and 5 years of age.** When ~~four- and five-year-old~~children 4 and 5 years of age are in care the requirements listed in this subsection are met.

(1) Basic items required are:
(A) one cot, bed, or mat per child;
(B) separate, individual space for personal belongings;
(C) table space with a chair, stool, or bench that allows 18 inches for each child;
(D) two linear-feet of low open shelves per child in each room for play equipment;
(E) sheet and cover, one per child;
(F) extra supply of sheets and covers;
(G) adequate supply of facial tissue, bath towels, wash cloths, and soap~~, and towels~~;
(H) sufficient clothing in various sizes in case of accidents; and
(I) a place to go, for example, a barrel, tented area, playhouse, bean-bag chair, or designated quiet area.

(2) Additional equipment is provided ~~in accordance with~~per OKDHS Appendix L-5.

(g) **Minimum equipment for school-age children.** When school-age children are in care the requirements listed in this subsection are met.

(1) Basic items required are:
(A) one cot, bed, or mat with a sheet and cover for children with scheduled nap times or an ill child;
(B) adequate table and chair space available at any given time;
(C) assigned, individual space for personal belongings;
(D) two linear-feet of shelf space per child ~~which~~that may be at various heights if accessible to children;
(E) safe storage for ongoing projects and small items;
(F) adequate supply of facial tissue, bath towels, wash cloths, soap, ~~towels,~~ and feminine hygiene products; and
(G) sufficient clothing in various sizes in case of accidents.

(2) Additional equipment is provided ~~in accordance with~~per OKDHS Appendix L-5.

## PART 2. ~~REQUIREMENT~~REQUIREMENTS FOR PART-DAY CHILDREN'S PROGRAMS

**340:110-3-45. Indoor equipment**

(a) **General.** The required equipment will assist staff in providing for the physical, intellectual, emotional, and social development of each child.

(1) A variety of equipment ~~shall be~~is accessible to all children on a daily basis.

(2) Play equipment ~~shall be~~is:

(A) complete, sturdy and in good working condition;

(B) maintained in a safe and sanitary condition;

(C) lead free~~, e.g.,~~for example, crayons, paint;

(D) of appropriate size and type to meet the developmental needs of ~~that~~each age group;

(E) provided in quantities proportionate to the number of children in each age group and the number of children for which the program is licensed.

(3) Sleeping equipment and bedding ~~shall meet the~~meets requirements ~~in~~per OAC 340:110-3-49.1.

(4) Indoor climbing equipment over four feet high ~~shall have~~has impact-absorbing mats in fall zones.

(5) To ensure safety, staff ~~shall monitor~~monitors play equipment for potential hazards~~, e.g.~~ for example, toys with strings, loose parts, or sharp edges~~, etc~~.

(6) The director ~~shall~~ constantly ~~re-evaluate~~re-evaluates equipment as enrollment varies.

(b) **Minimum equipment for infants.** When infants are in care, the requirements listed in this subsection shall be met.

(1) Basic items required are:

(A) crib or playpen with mattress, one per child;

(B) crib sheets and covers, one of each per child;

(C) high chair, one for every four infants;

(D) diaper-changing table;

(E) adult-height shelf;

(F) individual, adult-size chair for each staff person;

(G) separate, individual space for personal belongings;

(H) adequate ~~container~~containers with tight-fitting ~~lid~~lids or moisture-proof bags for soiled or wet diapers or clothing;

(I) adequate supply of diapers, facial tissue, disposable wipes or wash cloths, soap, and bath towels~~, etc.~~; and

(J) extra supply of sheets and covers.

(2) Cribs ~~shall~~ meet the requirements for safety contained in (A)-~~(D)~~(C) of this paragraph.

(A) ~~Cribs, port-a-cribs and playpens shall not have more than two and 3/8 inches between slats or between the side and end panels.~~Cribs, including portable cribs that can be folded or collapsed without being disassembled, meet the current Consumer Product Safety Commission (CPSC) full-size and non-full size crib standards per Sections 1219 and 1220 of Title 16 of the Code of Federal Regulations.

(B) ~~Decorative cutout areas in crib end panels or tall decorative knobs on the corner posts, which can entrap a child's head or catch is or her clothing, are prohibited.~~Verification of compliance with CPSC standards is maintained for duration of crib use.

(C) Mattresses shall fit the crib snugly with no more than one inch between the mattress and crib.

~~(D) Drop-side latches shall hold sides securely and not be reachable by the child in the crib.~~

(3) Mattresses and playpen pads ~~shall be~~are at least one-inch thick and covered with a durable, washable, water-proof, form-fitting material.

(c) **Minimum equipment for toddlers.** When toddlers are in care, the requirements listed in this subsection ~~shall be~~are met.

(1) Basic items required are:

(A) a crib or playpen with mattress, mat or cot, one per child;

(B) a sheet and cover, one of each per child;

(C) adequate table and chair space or high chairs as needed for meals and snacks;

(D) baskets or low open shelves for toy storage;

(E) separate, individual space for personal belongings;

(F) an adult-height shelf;

(G) a diaper-changing table;

(H) adequate containers with tight-fitting lids or moisture-proof bags for soiled or wet diapers or clothing; and

(I) an adequate supply of diapers, ~~wash cloths, soap, bath towels,~~ facial tissue, disposable wipes, bath towels, wash cloths, soap, extra supply of sheets, and covers~~, etc~~.

(2) The program ~~shall comply~~complies with crib ~~safety features~~ safety features listed in (b)(2) of this Section.

(3) Mattresses and playpen pads ~~shall be~~are at least one-inch thick and covered with a durable, washable, water proof, form-fitting material.

(d) **Minimum equipment for ~~two-year-olds~~children 2 years of age.** When ~~two-year-old~~ children 2 years of age are in care, the basic items required are:

(1) a cot, bed, or mat with a sheet and cover for each resting or ill child;

(2) adequate table and chair space as needed for meals and snacks;

(3) separate, individual space for personal belongings;

(4) baskets or low open shelving for toy storage;

(5) adequate containers with tight-fitting lids for soiled diapers; and

(6) an adequate supply of diapers, facial tissue, disposable wipes or individual wash cloths, bath towels, and soap~~, bath towels, facial tissue~~.

(e) **Minimum equipment for ~~three-year-olds~~children 3 years of age.** When ~~three-year-old~~ children 3 years of age are in care, the basic items required are:

(1) a cot, bed, or mat with a sheet or cover, for each resting or ill child~~,(see also340:110-3-50(a)(2)~~refer to OAC 340:110-3-49.1(a) regarding parents ~~being~~ allowed to provide sleeping equipment~~)~~;

(2) separate, individual space for personal belongings;

(3) adequate table and chair space as needed for meals and snacks;

(4) two linear-feet of low open shelves per child for play equipment; and

(5) an adequate supply of facial tissue, disposable wipes or individual wash cloths, bath towels, and soap~~, and towels~~.

(f) **Minimum equipment for ~~four and five-year-olds~~children 4 and 5 years of age.** When ~~four and five-year-old~~ children 4 and 5 years of age are in care, the basic items required are:

(1) a cot, bed, or mat with a sheet and cover, for each resting or ill child;

(2) separate, individual space for personal belongings;

(3) adequate table and chair space as needed for meals and snacks;

(4) two linear-feet of low open shelves per child for play equipment; and

(5) an adequate supply of facial tissue, disposable wipes or individual wash cloths, bath towels, and soap ~~and towels~~.

(g) **Minimum equipment for school-age children.** When school-age children are in care, the basic items required are:

(1) a cot, bed, or mat with a sheet and cover for each resting or ill child;

(2) adequate table and chair space as needed for meals and snacks;

(3) separate, individual space for personal belongings;

(4) two linear-feet of shelving space per child ~~which shall be~~that may be at various heights and is accessible to children ~~and may be at various heights~~;

(5) safe storage for on-going projects and small items;

(6) an adequate supply of facial tissue, disposable wipes or individual wash cloths, bath towels, soap, ~~towels,~~ and feminine hygiene products; and

(7) sufficient clothing in various sizes in case of accidents.

## PART 5. REQUIREMENTS FOR FAMILY CHILD CARE HOMES AND LARGE FAMILY CHILD CARE HOMES

### 340:110-3-91.1. Rest time

(a) **Place to rest.**

(1) Each child has an appropriately sized, individual place to rest, such as a crib, playpen, bed, cot, or mat, with clean, individual bedding. The place to rest is maintained in a clean and sanitary condition and in good repair.

(2) Waterbeds, sofas, soft mattresses, bassinettes, stacked cribs, pillows, beanbag chairs, and other soft surfaces are prohibited as infant sleeping surfaces.

(b) **Mats.** Mats are not used for overnight care. When used for napping, each mat is:

(1) at least two inches thick and covered with a fitted, durable, washable, waterproof material; and

(2) only used on clean carpeted surfaces.

(c) **Cribs and playpens.** A crib, port-a-crib, or playpen with a firm waterproof mattress or pad and a tight-fitting sheet is used for each child younger than one year of age.

(d) **Crib, port-a-crib, and playpen safety features.**

(1) ~~Cribs, port-a-cribs, and playpens with more than 2 and 3/8 inches between slats or between the side and end panels are not allowed.~~Cribs, including portable cribs that can be folded or collapsed without being disassembled, meet the current Consumer Product Safety Commission (CPSC) full-size and non-full size crib standards per Sections 1219 and 1220 of Title 16 of the Code of Federal Regulations.

(2) ~~Cribs with decorative cutout areas in crib end panels or tall decorative knobs on the corner posts, that can entrap the child's head or catch the child's clothing, are not allowed.~~Verification of compliance with CPSC standards is maintained for duration of crib use.

(3) Mattresses ~~must be~~are tight-fitting with no more than one inch between the mattress and crib.

(4) ~~Drop-side latches hold sides securely and are not accessible by the child in the crib.~~

~~(5)~~ Pillows, quilts, comforters, sheepskins, stuffed toys, bumper pads, and other soft products are not permitted in infant cribs, playpens, or port-a-cribs.

(e) **Sleep positioning.**

(1) To reduce the risk of Sudden Infant Death Syndrome (SIDS), infants younger than 12 months of age are placed on their back for sleeping unless ~~there is~~ a medical reason is documented by a doctor~~,~~that the infant should not sleep in this position. Documentation is maintained at the facility.

(2) Infants who are able to turn themselves over are placed initially on their back for sleeping but allowed to sleep in a position they prefer.

(3) Children's heads and faces are not covered.

## PART 9. REQUIREMENTS FOR RESIDENTIAL CHILD CARE FACILITIES

### 340:110-3-157. Physical facility and equipment

(a) **New construction.** Special consideration is given when choosing the site for new construction as to ~~available~~ water availability for ~~fire-fighting~~firefighting and access to all areas of the building for rescue.

(b) **Square footage.** Habitable living area is provided as in (1) - (4) of this subsection, ~~which~~and does not include offices, bathrooms, ~~kitchen~~kitchens, ~~laundry~~laundries, hallways, ~~furnace~~furnaces, or utility areas.

(1) There is a total of 150 square feet of habitable living area, including sleeping space, for the first resident and 100 square feet for each additional resident.

(2) Each sleeping room for more than one resident has 70 square feet for the first resident and 50 square feet for each additional resident.

(3) Each sleeping room intended for one resident contains 110 square feet.

(4) All areas counted as habitable space have a minimum ceiling height of seven feet, six inches.

(c) **Basements.** Basements cannot be used for sleeping quarters.

(d) **Mobile homes.** Facilities cannot be located in mobile homes.

(e) **Storage of personal belongings.** Adequate space for storage of personal belongings for each resident is provided.

(f) **Staff sleeping quarters.** Staff sleeping quarters are separate from those of the residents, but near enough to assure supervision.

(g) **Staff space.** Facilities provide sufficient space separate from space used for program and treatment activities for administrative activities, individual counseling sessions, and other staff functions required by the program design.

(h) **Bathrooms.** Bathrooms are maintained in a clean and sanitary condition with adequate ventilation.

(1) At least one flush toilet, hand sink, and bathtub or shower in good working condition is available for ~~each~~every six residents. Bathrooms are convenient to sleeping quarters, living, and recreation rooms.

(2) Flush urinals may be substituted for not more than one-half the required number of toilets when provided to serve males only.

(3) Hand sinks, bathtubs, and showers have cold and hot water with temperatures between 100 and 120 degrees Fahrenheit.

(4) Toilet paper, soap, and individual sanitary towels are provided within easy access of residents.

(i) **Diaper changing.** A non-porous changing pad in good repair is used when changing diapers. The diaper-changing surface is used only for diaper changing and is sanitized after each diaper change. Staff members wash and scrub their hands thoroughly with dispensable soap and warm running water after each diaper change.

(j) **Sanitation and safety.** All habitable and non-habitable areas are maintained in a clean and sanitary condition, free of litter and hazards.

(1) Harmful substances and objects that are not essential to facility operation are not kept on the premises. Other poisonous, flammable, or harmful materials are kept under lock when not under the supervision of an authorized adult.

(2) All firearms are stored unloaded in a locked container, cabinet, or closet. Ammunition is stored in a locked area separate from firearms.

(3) Every closet door can be opened from inside the closet.

(4) Every bathroom door lock can be unlocked from the outside in an emergency. The opening device is readily accessible to staff.

(5) All rooms used by residents are maintained at an indoor temperature between 65 and 85 degrees Fahrenheit.

(6) Indoor and outdoor recreational equipment and supplies are maintained in good condition, and play areas are free of hazards at all times.

(7) Floors, walls, ceilings, doors, and windows are maintained in good condition.

(8) The exterior foundation, roof, and walls are weather-proofed and maintained in good condition.

(9) All areas used by residents are well-lighted.

(10) The safety and sanitary conditions of house parent quarters is the responsibility of the facility.

(k) **Furnishings and decor.** The facility supplies comfortable furniture, as appropriate, for all living areas. Furniture for residents' use is of sufficient quantity and appropriately designed to suit the age, size, and capabilities of the residents.

(1) Each resident has an individual bed that is large enough to ~~adequately~~ accommodate the resident adequately. Each bed has its own mattress and bedding.

(A) ~~Cribs, port-a-cribs, and playpens may not have more than 2-3/8 inches between slats or between side and end panels.~~

~~(B) Cribs do not have decorative cutout areas in crib end panels or tall decorative knobs on the corner posts.~~Cribs, including portable cribs that can be folded or collapsed without being disassembled, meet the current Consumer Product Safety Commission (CPSC) full-size and non-full size crib standards per Sections 1219 and 1220 of Title 16 of the Code of Federal Regulations.

(B) Verification of compliance with CPSC standards is maintained for duration of crib use.

(C) Crib or port-a-crib mattresses fit snugly with no more than one inch between the mattress and crib.

~~(D) Drop side latches hold sides securely and are not accessible by the child in the crib.~~

(2) Every bedroom and bathroom window is equipped with window treatments as needed for privacy.

(3) Broken, defective, or recalled furnishings and equipment are repaired or replaced.

(l) **Telephones.** An operable telephone is readily accessible to each living unit for emergency use.

(m) **Health regulations.** The facility complies with licensing regulations for buildings, utilities, grounds and food service sanitation ~~as outlined in~~per OAC 340:110-3-163 and 340:110-3-164 and is inspected annually by the appropriate state agency.

(n) **Fire safety.** The facility complies with the state fire marshal's office regulations for construction and fire safety and is inspected annually by the state fire marshal's office or its designee.

(o) **Environmental quality.** A facility not on local water and sewage supply systems is inspected annually by the Department of Environmental Quality.

*[OAR Docket #13-896; filed 5-22-13]*

# TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
# CHAPTER 1. ADMINISTRATION

*[OAR Docket #13-880]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Information
450:1-1-1.1. [AMENDED]
450:1-1-2. [AMENDED]
Subchapter 3. Contracts for Mental Health, Substance Abuse, and Residential Care Services
Part 1. Eligibility to Contract
450:1-3-5. [AMENDED]
Subchapter 9. Certification and Designation of Facility Services
450:1-9-1. [AMENDED]
450:1-9-3. [AMENDED]
450:1-9-4. [AMENDED]
450:1-9-5. [AMENDED]
450:1-9-5.1. [AMENDED]
450:1-9-5.2. [AMENDED]
450:1-9-5.3. [AMENDED]
450:1-9-6. [AMENDED]
450:1-9-6.1. [AMENDED]
450:1-9-7. [AMENDED]
450:1-9-7.1. [AMENDED]
450:1-9-7.2. [AMENDED]
450:1-9-7.3. [AMENDED]
450:1-9-7.4. [AMENDED]
450:1-9-8.1. [AMENDED]
450:1-9-9. [AMENDED]
**AUTHORITY:**
Oklahoma Department of Mental Health and Substance Abuse Services Board; 43A O.S. §§ 2-101, 3-110, 3-306, 3-306.1, 3-314.1, 3-315, 3-317, 3-318, 3-319 and 3-415; 74 O.S. §85.9G.
**DATES:**
**Comment period:**
February 2, 2013 through March 5, 2013
**Public hearing:**
March 8, 2013
**Adoption:**
March 22, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 17, 2013
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
In accordance with the Administrative Procedures Act the proposed rule revisions to Chapter 1 are part of the Department's review of Title 450. The proposed rules clarify existing and are intended to comply with statutory changes.

Proposed changes include updated definitions for target populations and definitions for staff requirements, clarifications on purpose and applicability related to certification, additional procedures to protect health and safety of persons served, procedures for additional reviews of facilities with limited experience in providing ODMHSAS certified services, and references to new types of ODMHSAS certification authorized by Title 43A.
**CONTACT PERSON:**
Gretchen Geis, Administrative Rules Liaison, Department of Mental Health and Substance Abuse Services, Post Office Box 53277, Oklahoma City, Oklahoma 73152-3277, (405) 522-2053.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL INFORMATION

### 450:1-1-1.1. Definitions

The following words or terms, as defined below, when used in Chapters 1, 15, 16, 17, 18, 21, 22, 23, 24, 27, 30, 50, 53, 55, 60, 65 and 70, shall have the following meaning, unless the context clearly indicates otherwise and will prevail in the event there is a conflict with definitions included elsewhere in Chapters 1, 15, 16, 17, 18, 21, 22, 23, 24, 27, 30, 50, 53, 55, 60, 65 and 70:

**"Administrative Hearing Officer"** means an individual who is an attorney licensed to practice law in the State of Oklahoma and is appointed by the Commissioner of ODMHSAS to preside over and issue a proposed order in individual proceedings.

**"AOA"** means American Osteopathic Association.

**"Behavioral Health Aide (BHA)"** means individuals must have completed sixty (60) hours or equivalent of college credit or may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience, and:

(A) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(B) must be supervised by a bachelor's level individual with a minimum of two years case management experience or care coordination experience; and

(C) treatment plans must be overseen and approved by a LBHP; and

(D) must function under the general direction of a LBHP and/or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

~~**"Behavioral Health Case Manager (BHCM)"** means an individual certified as a Behavioral Health Case Manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50.~~

**"Behavioral Health Rehabilitation Specialist (BHRS)"**~~means 1) Bachelor degree or above; and 2) ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or 3); CPRP (Certified Psychiatric Rehabilitation Practitioner) credential; or 4) Certification as an Alcohol and Drug Counselor (CADC). CADC's are allowed to provide substance abuse rehabilitative treatment to those with alcohol~~

~~and/or drug dependencies or addictions as a primary or secondary DSM-IV Axis I diagnosis.~~

(A) On or after 7/01/13, BHRS must be either a LBHP, CADC or certified as a Case Manager II pursuant to Chapter 50 of Title 450.

(B) BHRS designations made between July 1, 2010 through June 30, 2013 under the following criteria will continue to be recognized until June 30, 2014:

(i) Bachelor degree or above, and ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or

(ii) ODMHSAS letter reflecting that grandfathering application requirements have been met; or

(iii) CPRP (Certified Psychiatric Rehabilitation Practitioner) credential; or

(iv) Certification as an Alcohol and Drug Counselor (CADC). CADC's are allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or drug dependencies or addictions as primary or secondary DSM-IV Axis diagnosis.

**"Board"** means the Oklahoma State Board of Mental Health and Substance Abuse Services.

**"CARF"** means Commission on Accreditation of Rehabilitation Facilities (CARF).

**"Certification"** means a status which is granted to a person or an entity by the Oklahoma State Board of Mental Health and Substance Abuse Services or the ODMHSAS, and indicates the provider is in compliance with minimum standards as incorporated in OAC 450 to provide a particular service. In accordance with the Administrative Procedures Act, 75 O.S. § 250.3(8), certification is defined as a "license."

**"Certified Alcohol and Drug Counselor (CADC)"** means Oklahoma certification as an Alcohol and Drug Counselor.

**"Certified Behavioral Health Case Manager"** or **"~~CB-HCM"~~ "CM"** means any person who is certified by the ODMHSAS ~~to offer behavioral health case management services as one of the three (3) classifications of case manager within the confines of a mental health facility or drug or alcohol treatment facility that is operated by the department or contracts with the State of Oklahoma to provide behavioral health services.~~as a Behavioral Health Case Manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50.

**"Certified facility"** means any facility which has received a certification status by the Oklahoma State Board of Mental Health and Substance Abuse Services or the ODMHSAS.

**"Certification report"** means a written notice of the deficiencies developed by ODMHSAS Provider Certification.

**"COA"** means the Council on Accreditation of Services for Families and Children, Inc.

**"Contractor"** or **"contractors"** means any person or entity under contract with ODMHSAS for the provision of goods, products or services.

**"Employment Consultant (EC)"** means an individual who (i) has a high school diploma or equivalent; and (ii) successful completion of Job Coach training.

**"Entities"** or **"entity"** means sole proprietorships, partnerships and corporations.

**"Facilities"** or **"facility"** means entities as described in 43A O.S. § 1-103(7), community mental health centers, residential mental health facilities, community-based structured crisis centers, certified services for the alcohol and drug dependent, programs of assertive community treatment, eating disorder treatment, gambling addiction treatment, and narcotic treatment programs.

**"Family Support and Training Provider (FSP)"** means

(A) have a high school diploma or equivalent;

(B) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(C) successful completion of Family Support Training according to a curriculum approved by the ODMHSAS;

(D) pass OSBI background check;

(E) treatment plans must be overseen and approved by a LBHP; and

(F) must function under the general direction of a LBHP or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

**"Individual proceeding"** means the formal process employed by an agency having jurisdiction by law to resolve issues of law or fact between parties and which results in the exercise of discretion of a judicial nature.

**"Institutional Review Board"** or **"IRB"** means the ODMHSAS board established in accordance with 45 C.F.R. Part 46 for the purposes expressed in this Chapter.

**"Intensive Case Manager (ICM)"** means an individual who is designated as an ICM and carries a caseload size of not more than twenty-five (25) individuals. They are a LBHP, CADC, or certified as a Behavioral Health Case Manager II ~~or III~~, and have:

(A) a minimum of two (2) years Behavioral Health Case Management experience,

(B) crisis diversion experience, and

(C) successfully completed ODMHSAS ICM training.

**"IRB approval"** means the determination of the IRB that the research has been reviewed and may be conducted within the constraints set forth by the IRB and by other agency and Federal requirements.

**"Levels of performance"** or **"level of performance"** means units of service by types of service.

**"Licensed Alcohol and Drug Counselor"** or **"LADC"** means any person who is licensed through the State of Oklahoma pursuant to the provisions of the Licensed Alcohol and Drug Counselors Act.

**"Licensed Behavioral Health Professional"** or **"LBHP"** means:

(A) allopathic or osteopathic physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;

(B) practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(i) Psychology;
(ii) Social Work (clinical specialty only);
(iii) Professional Counselor;
(iv) Marriage and Family Therapist;
(v) Behavioral Practitioner; or
(vi) Alcohol and Drug Counselor;

(C) advanced practice nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided; or

(D) a physician assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or therapy functions.

**"Licensed dietitian"** means a person licensed by the Oklahoma Board of Medical Licensure and Supervision as a dietitian.

**Licensed mental health professional"** or **"LMHP"** as defined in Title 43A §1-103(11).

**"Licensed physician"** means an individual with an M.D. or D.O. degree who is licensed in the state of Oklahoma to practice medicine.

**"Licensed practical nurse"** means an individual who is a graduate of an approved school of nursing and is licensed in the State of Oklahoma to provide practical nursing services.

**"Minimal risk"** means that the probability and magnitude of harm or discomfort anticipated in the research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests.

**"ODMHSAS"** or **"Department"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"Oklahoma Administrative Code"** or **"OAC"** means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

**"Paraprofessional"** means a person who does not have an academic degree related to the scope of treatment or support services being provided but performs prescribed functions under the general supervision of that discipline.

**"Probationary certification"** means a certification status granted for a period less than three (3) years.

**"Psychiatrist"** means a licensed physician who specialized in the assessment and treatment of individuals having psychiatric disorders and who is fully licensed to practice medicine in the state in which he or she practices and is certified in psychiatry by the American Board of Psychiatry and Neurology, or has equivalent training or experience.

**"Recovery Support Specialist"** or **"RSS"** means an individual who has completed the ODMHSAS RSS training (also referred to as Peer Recovery Support Specialist (PRSS) training) and has passed the ODMHSAS RSS exam.

**"Registered nurse"** means an individual who is a graduate of an approved school of nursing and is licensed in the state of Oklahoma to practice as a registered nurse.

**"Rehabilitative services"** means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life.

**"Reimbursement rates"** means the rates at which all contractors are reimbursed (paid) for services they provide under their ODMHSAS contract, and which are reported to ODMHSAS on the Integrated Client Information System ("ICIS").

**"Research"** means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this Chapter, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities.

**"Respondent"** means the person(s) or entity(ies) named in a petition for an individual proceeding against whom relief is sought**.**

**"Service area"** means a geographic area established by the Department of Mental Health and Substance Abuse Services for support of mental health [43A O.S. § 3-302(1)].

**"Service Provider"** means a person who is allowed to provide substance abuse services within the regulation and scope of their certification level or license.

**"Site Review Protocol"** means an ODMHSAS document developed as a work document in the certification site visit(s) that is based primarily upon the rules (standards/criteria) being reviewed. The Site Review Protocol is used in preparing the Certification Report, which is provided to the facility, and in preparing recommendations regarding certification to the Board for its consideration and action.

**"Support Services Provider (SSP)"** means an individual age eighteen (18) or older with a high school diploma or equivalent.

**"TJC"** means The Joint Commission formerly referred to as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO.

**"Volunteer"** means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

**450:1-1-2. Applicability**

This, and all subsequent chapters are applicable, unless otherwise specifically noted in a chapter, subchapter, part or section of Oklahoma Administrative Code Title 450, to the Oklahoma Department of Mental Health and Substance Abuse Services, the State Board of Mental Health and Substance Abuse Services, and:

(1) all employees and institutions and facilities of ODMHSAS (43A O.S. §§ 3-101 and 3-107); and

(2) all facilities (43A O.S.§§ 1-103(7), 3-306.1, 3-315, 3-317, 3-319, 3-320, 3-222, 3-323A, and 3-415) under contract with ODMHSAS; and

(3) all facilities subject to certification by ODMHSAS (43A O.S. §§ 3-306.1, 3-315, 3-317, 3-319, 3-320, 3-222, 3-415, 3-601); and

(4) institutions, organizations and individuals subject to certification by ODMHSAS to provide alcohol and drug substance abuse courses (43A O.S. §§ 3-451 through 3-453); and

(5) agencies and individuals subject to certification by ODMHSAS to provide alcohol and drug assessment and evaluation programs related to driver's license revocation [47 O.S. §§ 11-902(G) and 6-212.2; 43A O.S. § 3-460];~~and~~

(6) individuals subject to certification to be a behavioral health case manager pursuant to 43A O.S. § 3-318~~.~~; and

(7) Individuals subject to certification to be recovery support specialist to 43A O.S. § 3-326.

## SUBCHAPTER 3. CONTRACTS FOR MENTAL HEALTH, SUBSTANCE ABUSE, AND RESIDENTIAL CARE SERVICES

## PART 1. ELIGIBILITY TO CONTRACT

**450:1-3-5. Staff qualifications for contracted entities**

(a) All staff who provide clinical or supportive services for an agency contracting with ODMHSAS shall have documented qualifications, licensing or training specific to the clinical services they provide.

(b) The following service providers, as defined in 450:1-1-1.1, may provide behavioral health treatment and support services as agreed upon per contact between ODMHSAS and the contractor:

(1) Behavioral Health Aide (BHA);

(2) Behavioral Health Case Manager ~~(BHCM)~~(CM);

(3) Behavioral Health Rehabilitation Specialist (BHRS);

(4) Certified Alcohol and Drug Counselor (CADC);

(5) Employment Consultant (EC);

(6) Family Support and Training Provider (FSP);

(7) Intensive Case Manager (ICM);

(8) Licensed Behavioral Health Professional (LBHP);

(9) Licensed Mental Health Professional (LMHP);

(10) Licensed Physician;

(11) Licensed Practical Nurse;

(12) Paraprofessional;

(13) Psychiatrist;

(14) Recovery Support Specialist (RSS);

(15) Registered Nurse;

(16) Support Services Provider (SSP).

(c) Compliance with 450:1-3-5 shall be determined by a review of staff personnel files and other supporting documentation provided.

## SUBCHAPTER 9. CERTIFICATION AND DESIGNATION OF FACILITY SERVICES

**450:1-9-1. Applicability of certification**

This subchapter applies to all entities and individuals which are subject to certification ~~or credentialing~~ by the Board, or the Commissioner or designee.

**450:1-9-3. Purpose of certification**

The purpose of ODMHSAS certification is to assess~~,~~ each facility's responsibility to the consumer, and delivery of acceptable services to the consumer. Responsibility to the consumer is demonstrated through the provision of suitable facilities, trained staff and needed services which are accessible, safe and confidential. In addition to the above, is demonstrated by the willingness and ability of the ~~organization's~~facility's governing authority and staff to provide the planning, budgeting and management of resources necessary to the continued existence and effectiveness of the facility/services.

**450:1-9-4. Reviewing authority**

(a) The Board may certify community mental health centers, community residential mental health facilities, community-based structured crisis centers, eating disorder treatment programs, alcohol and drug treatment programs, outpatient mental health treatment programs (mental illness treatment programs), comprehensive addiction treatment centers, programs of assertive community treatment, gambling addiction treatment programs, and narcotic treatment programs as cited in Section 450:1-9-1, and directs that such shall be carried out as stated in this subchapter.

(b) The Board, or the Commissioner, or designee~~and ODMHAS~~ may also certify qualified individuals to perform within the scope of specific functions to provide treatment or support services related to behavioral health services. Certification of individuals shall be carried out as stated in OAC 450:1 and in accordance with applicable requirements specified in other chapters of OAC 450.

(c) The Commissioner of ODMHSAS may grant or extend a Permit for Temporary Operations to respond to unplanned changes that create an emergency need for service provision in the ~~ODMHSAS~~public behavioral health delivery system for services operated by or funded by ODMHSAS.

(1) Provider Certification shall conduct a site review at the designated facility which must meet the minimal compliance requirements as cited in 450:1-9-7.

(2) The application procedure for completion of the certification process shall be accomplished in accordance with 450:1-9-6 and 450:1-9-7.

(3) The Permit for Temporary Operations emergency certification status granted to the facility by the Commissioner as described above must be presented at the next ODMHSAS Board meeting for Board review and confirmation. In the event the Board does not confirm the Temporary Certification status granted by the Commissioner, the Permit for Temporary Operations expire no later than thirty (30) days from the Board's action as stipulated in a written notice provided to the organization for which the Permit was denied.

**450:1-9-5. Qualifications for certifications of facilities and programs and individuals**

(a) Qualifications for certification are as follows:

(1) Compliance with applicable Standards and Criteria as authorized within the authority of Title 43A of the Oklahoma Statutes including but not limited to those formally codified~~set forth~~ in the ~~Chapter of OAC~~ Title 450 regulating the area for which certification is ~~being~~ sought ~~is required to qualify for certification. Recovery Support Specialists shall comply with applicable requirements and procedures specified by the Department~~. ~~Other specific~~Codified Standards and Criteria include but are not limited to~~are~~:

(A) Chapter 16, Standards and Criteria for Community Residential Mental Health Facilities;

(B) Chapter 17, Standards and Criteria for Community Mental Health Centers;

(C) Chapter 18, Standards and Criteria for Alcohol and Drug Treatment Programs;

(D) Chapter 21, Certification of Alcohol and Drug Substance Abuse Courses (ADSAC), Organizations and Facilitators;

(E) Chapter 22, Certification of Alcohol and Drug Assessment and Evaluations Related to Driver's License Revocation;

(F) Chapter 23, Standards and Criteria for Community Based Structured Crisis Centers;

(G) Chapter 24, Standards and Criteria for Comprehensive Community Addiction Recovery Centers;

(H) Chapter 27, Standards and Criteria for Mental Illness Service Programs;

(~~G~~I) Chapter 50, Standards and Criteria for Certified Behavioral Health Case Managers;

(J) Chapter 53, Standards and Criteria for Certified Peer Recovery Support Specialists;

(~~H~~K) Chapter 55, Standards and Criteria for Programs of Assertive Community Treatment;

(~~I~~L) Chapter 60, Standards and Criteria for Certified Eating Disorder Treatment Programs;

(~~J~~M) Chapter 65, Standards and Criteria for Gambling Treatment Programs; and

(~~K~~N) Chapter 70, Standards and Criteria for Opioid Substitution Treatment Programs.

(2) ~~Subsequent to the adoption of this rule,~~ ODMHSAS will designate specific standards in the Chapters listed above, that are applicable to facilities and programs, as Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards and the requirements that must be present to determine minimal compliance with each type of standard

(A) Core Organization Standards will address requirements necessary to assure the public and consumers of services that essential organizational functions are substantially in place at the facility and the facility is prepared to initiate services for which certification is being requested. These can be verified prior to the initiation of services for which the organization is requesting certification.

(B) Core Operational Standards will address other essential conditions and processes that must be in place to assure basic safety and protection of consumer rights. Some of these can also be verified prior to the initiation of service. Others must be verified when an organization begins providing services.

(C) Quality Clinical Standards will address actual services provided, qualifications of staff, clinical documentation, and processes designed to assure consistency in quality and efficacy of services. These can only be verified after a reasonable time during which services have been provided.

(3) For each Chapter listed above ODMHSAS will designate certain core organizational, core operational and clinical standards that will be considered critical to the protection of the health, safety and welfare of the clients. Failure to meet these will result in immediate suspension and/or revocation.

(4) An applicant for certification must also comply with all other applicable statutory licensing provisions, including but not limited to individual professional licensure, other licenses, or permits required of organizational entities.

(b) A certified Community Mental Health Center that provides alcohol and drug treatment services in the course of its outpatient or inpatient services, but has no designated or specialized alcohol and drug abuse treatment program component, shall not be subject to additional certification under the Certified Services for Alcohol- and Drug-Dependent Standards and Criteria in OAC 450, Chapter 18.

(c) A certified Community Mental Health Center providing alcohol and drug abuse treatment services as a designated or specialized program component shall be subject to certification under the Certified Services for Alcohol- and Drug-Dependent Standards and Criteria in OAC 450, Chapter 18 or Comprehensive Community Addiction Recovery Centers Standards and Criteria in OAC 450, Chapter 24.

~~(d) Certified Services for the Alcohol- and Drug-dependent providing community mental health services shall be subject to certification as a community mental health center in OAC 450, Chapter 17.~~

**450:1-9-5.1. Types and duration of certification status for facilities and programs**

(a) The ODMHSAS may grant the following types of certification for the durations specified below.

(1) **Permit for Temporary Operations.** Permits for temporary operations ~~will~~ may be granted ~~by ODMHSAS~~ upon ODMHSAS's verification that the organization has complied with all Core Organizational Standards and Core Operational Standards applicable to the related type~~level~~ of services for which certification ~~applies~~ is sought. In addition, for facilities that have provided services for 30 days or longer applicable to this type of certification ODMHSAS may review compliance with applicable Quality Clinical Standards. The Permit will expire at the end of six (6) months or if a subsequent certification is achieved by the organization and subsequently granted by ODMHSAS prior to the expiration of the Permit. ODMHSAS may extend a Permit for no more than 60 days in the event of extenuating circumstances as determined by ODMHSAS.

(2) **Probationary Certification.** ProbationaryCertification may be awarded for a one (1) year period by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 and when ODMHSAS verifies that all conditions in 450:1-9-5.1(a)(3)exist but the program initiated operations prior to the awarding of a Permit for Temporary Operations for the services for which certification is statutorily required. Organizations awarded Probationary Certification must apply for and be awarded Probationary Certification for two additional one (1) year terms, prior to being considered for other categories of ~~ODMSHAS~~ODMHSAS Certification.

(3) **Certification.** ODMHSAS may award Certification for a one (1) year or two (2) year period beyond the period approved for a Permit for Temporary Operations or as a renewal of a previously awarded Certification in accordance with applicable chapters as stipulated in 450:1-9-5 and when ODMHSAS determines that the organization has met minimal compliance with each type of standard (i.e. Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards). To qualify for Certification, programs must meet the following:

(A) Demonstrate compliance with all Core Organizational Standards and with all Core Operational Standards as verified by ODMHSAS and within timeframes stipulated by ODMHSAS; and,

(B) For a one (1) year certification, demonstrate compliance with at least 51% of all Quality Clinical Standards on the initial site review, and file an acceptable plan of correction and demonstrate compliance with 100% of Quality Clinical Standards, as verified by ODMHSAS in accordance 450:1-9-7.1 and 450:1-9-7.3; or,

(C) For a two (2) year certification, demonstrate compliance with at least 75% of all Quality Clinical Standards on the initial site review, and file an acceptable plan of correction and demonstrate compliance with 100% of Quality Clinical Standards, as verified by ODMHSAS in accordance 450:1-9-7.1 and 450:1-9-7.3.

(D) Community Residential Mental Health Programs can be recommended for no more than a one (1) year certification.

(E) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.1(3) until all conditions of 450:1-9-5.1(2) have been satisfied.

(4) **Certification with Distinction.** Certification with Distinctionmay be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 for programs seeking renewal of previously awarded certification when ODMHSAS verifies all of the following minimal conditions are satisfied.

(A) Programs must have provided services with an approved ODMHSAS Certification as described in 450:1-9-5.1(3) for one (1) year or longer in addition to the time services were provided under an approved Permit for Temporary Operations or a Probationary Certification.

(B) Programs must demonstrate compliance with all Core Organizational Standards and with all Core Operational Standards as verified by ODMHSAS; and,

(C) Programs must also demonstrate compliance with at least 90% of all Quality Clinical Standards on the initial renewal site visit and review as verified by ODMHSAS. Compliance may be determined during initial site reviews or during additional site reviews following the implementation of a plan of correction as required ODMHSAS, in accordance 450:1-9-7.1 and 450:1-9-7.3.

(D) Programs for which ODMHSAS determines compliance with all standards as required in (a), (b), and (c) ~~will~~may be recommended for Certification with Distinction for a three (3) year period.

(E) ODMHSAS may refund certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e. Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.

(F) Community Residential Mental Health Programs can be recommended for no more than a one (1) year Certification with Distinction.

(G) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.1(4) until all conditions of 450:1-9-5.1(2) have been satisfied.

(5) **Certification with Special Distinction.** Certification with Special Distinctionmay be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 for programs seeking renewal of previously awarded certification when ODMHSAS verifies all of the following minimal conditions are satisfied.

(A) The program must meet all conditions for Certification with Distinction as outlined in 1-9-5.1 (4); and,

(B) The program has attained national accreditation (COA, CARF, or TJC) for the services to which ODMHSAS Certification applies.

(C) Certification with Special Distinction will be reduced by ODMHSAS to Certification with Distinction by ODMHSAS if during the certification period for which the Special Distinction was approved, the program fails to maintain national accreditation status.

(D) ODMHSAS may refund certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e. Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.

(E) Community Residential Mental Health Programs can be recommended for no more than a one (1) year Certification with Distinction.

(F) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.1(4) until all conditions of 450:1-9-5.1(2) have been satisfied.

(b) Permits for Temporary Operations granted to applicants for initial certification of a facility, location, or level of service shall be for a period of six (6) months and shall become effective immediately upon approval by the ODMHSAS Board, the Commissioner or designee.

(c) Certification, other than Permits for Temporary Operations, granted to an applicant shall become effective the first day of the month following the date of the action by the Board, provided however, the Board may waive this requirement and make the Certification effective immediately.

**450:1-9-5.2. Types and Duration of certification of individuals**

(a) Certification for Behavioral Health Case Managers will be in accordance with requirements and procedures stipulated in 450:50 Certification of Behavioral Health Case Managers.

(b) Certification for organizations and individuals providing alcohol and drug abuse course instruction will be in accordance with requirements and procedures stipulated 450:21 Certification of Alcohol and Drug Substance Abuse Courses (ADSAC), Organizations and Facilitators.

(c) Certification related to alcohol and drug assessment and evaluation related to driver's licenses revocation will be in accordance with requirements and procedures stipulated in 450:22, Certification of Alcohol and Drug Assessment and Evaluations Related to Driver's License Revocation.

(d) ~~Credentialing~~Certification for Recovery Support Specialists will be as done in accordance with ~~procedures and guidelines established by ODMHSAS~~requirements and procedures stipulated in 450:53 Certification of Recovery Support Specialists.

**450:1-9-5.3. Additional conditions related to certification**

(a) Certification ~~and credentials~~ granted by ODMHSAS ~~are~~is not transferable. A change of the ownership of a facility automatically terminates any certification status, requiring application for certification by the new ownership.

(1) If the certified facility is owned by a corporation the following applies:

(A) If the corporation is not-for-profit, a change in membership of the Board of Directors of more than fifty percent (50%) of the Directors in three (3) or less calendar months, unless such change was caused by the normal expiration of terms in accordance with the bylaws of the Board of Directors, shall require the facility to be recertified.

(B) If the corporation is other than not-for-profit, a change in the ownership of more than forty per cent (40%) of the stock in the corporation from the owners at the beginning of the period of certification shall require the facility to be recertified.

(2) It is the responsibility of the facility to notify the ODMHSAS of the occurrence of either of the conditions requiring recertification and to request the application materials for recertification.

(b) Organizations granted certification, including Permits for Temporary Operation, shall only publically refer to ODMHSAS Certification in relationship to the specific services, locations, and dates applicable to each currently granted ODMHSAS Certification. This includes all published materials, electronic media, and information posted within a facility. Failure to adhere to this restriction can be cause for action related to Certification in accordance with 1-5-4.

(c) ODMHSAS shall conduct at least one unannounced additional certification site visit during each one (1) year term of a program granted Probationary Certification and each program granted 1-Year Certification.

(1) A site visit report will be supplied to the program or facility within five (5) days of the site visit unless precluded by extenuating circumstances.

(2) If deficiencies are noted, the program or facility must file a Plan of Correction addressing all deficiencies within ten (10) days of receipt of the report.

(3) Deficiencies verified during the unannounced site visit that indicate danger to the health, safety and/or welfare of the clients will result in immediate suspension and/or revocation.

(d) Programs or facilities that score within a one-year Certification range, as described in 450:1-9-5.1 (3), for three successive years, may not be recommended for renewal of certification for the third year and may be recommended for initiation of revocation proceedings.

(e) Certification ~~or credentials~~ may be suspended or revoked with the basis for such action being delineated in Section 450:1-9-9 of this Subchapter.

**450:1-9-6. Procedures for application for certification**

(a) Applications for certification as a community mental health center, community residential mental health facility, community-based structured crisis center, comprehensive community addiction recovery centers, mental illness service programs, eating disorder treatment program, alcohol and drug treatment program, program of assertive community treatment, gambling addiction treatment program, and narcotic treatment program must be made to ODMHSAS in writing on a form and in a manner prescribed by the Commissioner of ODMHSAS and include the following:

(1) A fully completed ODMHSAS application for certification form signed by authorized officials;

(2) The necessary written documentation or supporting evidence required on the application for certification form; and

(3) The required certification fee in the form of a check or money order, payable to the Oklahoma Department of Mental Health and Substance Abuse Services.

(4) The following fees are required:

(A) Application fee for all Treatment Programs is $300 per certification period.

(B) Application fee for Community Residential Mental Health Programs is $100 per certification period.

(5) The application for certification form, required written documentation and fee must be submitted to Oklahoma Department of Mental Health and Substance Abuse Services, Provider Certification Division, P.O. Box 53277, Oklahoma City, Oklahoma 73152-3277.

(6) The application may require a listing of all services provided by the applicant, as well as specifics about the applicant including but not limited to governing authority, administrative, fiscal, all locations or sites where applicant will provide services and types of services to be provided.

(7) The application may require a listing of key personnel, including a clinical director, currently licensed in the clinical area(s) for which certification is sought.

(8) ODMHSAS may refund certification fees based on exemplary performance during the Certification process for which the application has been submitted and based on guidelines established by ODMHSAS.

(b) Applications for certification or credentials as individual must be made to ODMHSAS in writing on a form and in a manner prescribed by the Commissioner of ODMHSAS and, as applicable, in accordance with specific requirements stipulated in the following chapters of 450:21, 450:22, 450:50, and for Recovery Support Specialist, in accordance with application instructions stipulated by ODMHSAS.

(c) Failure to provide required materials within a timely manner or to the extent required will result in a denial of the application.

**450:1-9-6.1. Expanding certification of facilities and programs to additional geographical areas; Adding new programs or levels of care**

(a) A facility or program, after being certified, may request to add a service location within the geographic area, in which the facility's currently provides certified services ~~or to extend services to a different geographic area. Approval may be granted by the Commissioner upon submission of the required documentation of the Provider Certification Division provided the organization is not certified under a Permit for Temporary Operations.~~

~~(1) The facility must notify ODMHSAS in writing of the plan to expand service locations on a form and in a manner prescribed by the Commissioner of ODMHSAS.~~

~~(2) The required written documentation or supporting evidence includes, but is not limited to:~~

~~(A) fire & safety inspection;~~

~~(B) facility policies and procedures;~~

~~(C) zoning compliance; and~~

~~(D) evidence of compliance with Title 43A O.S. §3-417.1, if applicable.~~

(b) For purposes of 1.9-6.1, the facility's or program's geographic area is limited to the county in which the currently certified program's or facility's main office is located or an immediately contiguous county. Except for a Certified Community Mental Health Center, the geographic area will be defined as the service area established by ODMHSAS in accordance with 43A O.2 § 3-302 (1).

(c) Approval may be granted by the Commissioner upon submission of the required documentation to the Provider Certification Division provided the organization is not certified under a Permit for Temporary Operations.

(1) The facility must notify ODMHSAS in writing of the plan to expand service locations on a form and in a manner prescribed by the Commissioner of ODMHSAS.

(2) The required written documentation or supporting evidence includes, but is not limited to:

(A) fire & safety inspection;

(B) facility policies and procedures;

(C) zoning compliance; and

(D) evidence of compliance with Title 43A O.S. §3-417.1, if applicable.

(~~b~~d) At the time of the next review of the facility's main office certification, any location which extended service provision to a different geographic area will require a separate certification application and may be reviewed on a schedule separate and apart from the certification schedule of the main office.

(~~c~~e) If after being certified, a facility desires to offer a new type of service or new level of care, for which certification is required, the facility must submit an application for certification, the required documentation and fee to the ODMHSAS Provider Certification Division, P.O. Box 53277, Oklahoma City, Oklahoma 73152-3277.

**450:1-9-7. Procedures for completion of the Permit for Temporary Operations certification process**

(a) Completion of the certification process for a Permit for Temporary Operations will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

(1) Each organization pursuing ODMHSAS certification shall initially apply for a Permit for Temporary Operations.

(2) Upon receipt of an application ODMHSAS will provide all applicants for a Permit for Temporary Operations a document listing the Core Organizational Standards, ~~and~~ Core Operational Standards, and Quality Clinical Standards required for a Permit for Temporary Operations. For facilities or programs that have provided clinical services for 30 days or longer, at the time of the initial application, ODMHSAS may also review applicable Quality Clinical Standards.

(3) The application shall be reviewed for completeness by ODMHSAS staff ~~as referenced in 1-9-6~~. If the application is deemed complete, a site review of the facility or program will be scheduled and completed. Failure to provide required materials within a timely manner or to the extent required will result in a denial of the application.

(4) Any deficiencies of applicable Core Organizational Standards and Core Operational Standards, and Quality Clinical Standards cited as a result of the site visit or subsequent review(s) of documents requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the site visit unless precluded by extenuating circumstances.

(5) The facility will have ten (10) working days from receipt of the deficiency report to correct deficiencies related to Core Organizational and Core Operational Standards and provide to ODMHSAS proof of compliance. ODMHSAS may ~~require~~conduct an additional site visit(s) to verify proof of compliance.

(6) If any pending deficiencies in Core Organizational Standards and Core Operational Standards are identified following this ten (10) day correction period, the program will have five (5) additional working days from receipt of any subsequent report to correct and verify compliance with any pending deficiencies.

(7) ~~Failure of any applicant for a Permit for Temporary Operation to clear deficiencies of Core Organizational Standards or Core Operational Standards within twenty (20) working days of the initial site visit, shall result in a notice of denial of the application for a Permit for Temporary Operations.~~ The following additional procedures will apply to programs or facilities reviewed for Quality Clinical Standards pursuant to an application for Permit for Temporary Operation as referenced in 1-9-7 (2) above.

(A) The facility will also have ten (10) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule an additional site visit or documentation review to determine compliance with Quality Clinical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in (5) above.

(B) Any deficiencies of applicable standards identified during the additional site visit or review referenced in (A) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards during the follow up site visit or review referenced in (A) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a recommendation related to certification. Facilities desiring this additional review must do so in writing to the Director of Provider Certification within three (3) working days of receipt of thefollow up report referenced in (A) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (A) above.

(8) ~~Applicants that clear pending deficiencies and for whom ODMHSAS can verify compliance with all applicable Core Organizational Standards and Core Operational Standards within twenty (20) working days of the initial site visit, will recommended for a Permit for Temporary Operation by ODMHSAS.~~ Facilities for which ODMHSAS can verify compliance with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards, within the timeframes specified in (3) through (7) above may be recommended for Permit for Temporary Operationin accordance with guidelines established in 450:1-9-5.1.

(9) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

(10) Failure of any applicant for a Permit for Temporary Operation to clear deficiencies of all applicable Standards within timeframes stipulated in (3) through (7), shall result in a notice of denial of the application for a Permit for Temporary Operations

(b) Additional certification procedures related to a Permit for Temporary Operations.

(1) Re-application for a Permit can be accepted no sooner than ninety (90) days after issuance of a notification of denial.

(2) If an applicant fails a second time to satisfy requirements for a Permit for Temporary Operations as stipulated in 450:1-9-7(a)(8), ODMHSAS can accept an additional re-application no sooner than twelve (12) months from time of the issue of the second notification of denial.

(3) Organizations granted a Permit for Temporary Operations must achieve a subsequent level of ODMHSAS certification prior to the expiration of a Permit for

Temporary Operations. Failure to do so will result in a cancellation by ODMHSAS of the Permit for Temporary Operations. ODMHSAS will provide notice of the cancellation and stipulate to the organization that it is must discontinue services subject to any statutory provisions that mandate the applicable ODMHSAS Certification. Re-application for a Permit for Temporary Operations, following a cancellation by ODMHSAS or by the organization to which a Permit was issued, may occur after ninety (90) days and in accordance with the requirements of 450:1-9-7 and 450:1-9-12.

**450:1-9-7.1. Procedures for completion of additional certification processes subsequent to a Permit for Temporary Operations**

(a) The following procedures apply for organizations awarded Permit for Temporary Operation pursuant to 450:1-9-7 that elect to progress to an additional certification by ODMHSAS. The process outline below will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

(1) Ninety (90) days prior to the expiration of a Permit for Temporary Operations, ODMHSAS will notify the permitted facility that a supplemental certification application form must be completed so the organization can be reviewed for a new certification level. Along with a request for a supplemental certification application, ODMHSAS will provide a document listing Quality Clinical Standards applicable to the new certification level. The document will also indicate the Core Organization Standards and Core Operational Standards for which continued compliance must be verified.

(2) Each organization desiring to be considered for certification subsequent to being awarded a Permit for Temporary Operations will complete a supplemental certification application form at least sixty (60) days prior to the expiration of the Permit for Temporary Operations.

(3) In the event an organization, after being awarded a Permit for Temporary Operations, fails to supply the supplemental certification application in accordance with (1) and (2) above or elects to not pursue further ODMHSAS certification, the Permit for Temporary Operations will be allowed to expire.

(4) No additional fee, beyond that required for a Permit for Temporary Operation will be required along with the supplemental certification application.

(5) The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site review of the facility or program will be scheduled and completed.

(6) Any deficiencies of applicable standards identified as a result of the subsequent certification site visit or documentation reviews requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the site visit unless precluded by extenuating circumstances.

(7) The facility will have ten (10) working days from receipt of the report to correct deficiencies of all Core Organizational Standards and Core Operational Standards and provide ODMHSAS proof of compliance with these standards. ODMHSAS may require an additional site visit(s) to determine of compliance with Core Organizational Standards and Core Operational Standards. The facility will have no more than twenty (20) working days from the certification site visit referenced in (6) above to achieve complete compliance with all Core Organizational Standards and Core Operational Standards.

(8) The facility will also have ten (10) working days from receipt of the report to submit a plan for correction related to deficiencies in Quality Clinical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule a site visit or documentation review to determine compliance with Quality Clinical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in (6) above. The site visit or review may or may not be conducted in conjunction with a review to verify compliance with pending Core Organizational Standards, and Core Operational Standards.

(9) Any deficiencies of applicable standards identified during the site visit or review referenced in (8) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards during the follow up site visit or review referenced in (8) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a recommendation related to certification as referenced in (10) below. Facilities desiring this additional review must do so in writing to the Director of Provider Certification within three (3) working days of receipt of the follow up report referenced in (9) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (9) above.

(10) Facilities for which ODMHSAS can verify compliance with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards, within the timeframes specified in 450:1-9-7.1 ~~will~~ may be recommended for a certification status in accordance with guidelines established in 450:1-9-5.1.

(11) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

(12) If the applicant fails to submit a plan of correction within a required time frame or fails to submit a timely or adequate revised plan of correction, denial of the application for subsequent certification shall be sent to the applicant by the Commissioner or designee and the current Permit for Temporary Operations be allowed to expire. Likewise, if the applicant fails to request an additional site visit or documentation review in accordance with timeframes stipulated in (9) above denial of the application for

subsequent certification shall be sent to the applicant by the Commissioner or designee and the current Permit for Temporary Operations be allowed to expire

**450:1-9-7.2. Procedures for renewal of certification**

(a) The following procedures apply to organizations previously awarded certification pursuant to 450:1-9-7.1 and organizations that have maintained Certification or Certification with Commendation awarded by ODMHSAS prior to November 1, 2010. The process outline below can result in an entity being awarded Certification, Certification with Distinction, or Certification with Special Distinction. The process will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

(1) Ninety (90) days prior to the expiration of a current Certification, except a Permit for Temporary Operations, ODMHSAS will provide the certified the facility with a notice of certification expiration and advise the facility that a renewal certification application form must be completed so the organization can be reviewed for consideration for a renewal of certification. Along with the notice of certification expiration, ODMHSAS will provide a document listing Core Organization Standards, Core Operational Standards, and Quality Clinical Standards potentially applicable to the renewed certification.

(2) Each organization desiring to renew Certification must submit a completed certification application form, fees and other required materials in accordance with 450:1-9-6 and at least sixty (60) days prior to the expiration of the current Certification.

(3) In the event an organization, after being notified of the Certification expiration in accordance with (1) and (2) above fails to submit the renewal certification application, fees, or other materials as referenced in (2) above, the current Certification will be allowed to expire.

(4) The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site review of the facility or program will be scheduled and completed.

(5) Any deficiencies of applicable standards identified as a result of the renewal site visit or subsequent review(s) of documents requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the initial renewal site visit unless precluded by extenuating circumstances.

(6) The facility will have ten (10) working days from receipt of the report to correct deficiencies of all Core Organizational Standards and Core Operational Standards and provide to ODMHSAS proof of compliance with these standards. ODMHSAS may require an additional site visit to verify proof of compliance of Core Organizational Standards and Core Operational Standards. If deficiencies continue, the facility will have no more than twenty (20) working days from the initial renewal site visit to achieve complete compliance with all Core Organizational Standards and Core Operational Standards.

(7) The facility will also have ten (10) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule an additional site visit or documentation review to determine compliance with Quality Clinical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in (5) above. The site visit may or may not be conducted in conjunction with a site visit to verify compliance with pending Core Organizational Standards, and Core Operational Standards.

(8) Any deficiencies of applicable standards identified during the additional site visit or review referenced in (7) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards during the follow up site visit or review referenced in (8) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a recommendation related to certification as referenced in (10) below. Facilities desiring this additional review must do so in writing to the Director of Provider Certification within three (3) working days of receipt of the follow up report referenced in (8) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (8) above.

(9) Facilities for which ODMHSAS can verify compliance with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards, within the timeframes specified in 450:1-9-7.3 ~~will~~ may be recommended for renewal of Certification in accordance with guidelines established in 450:1-9-5.1.

(10) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

(11) If the applicant fails to submit a plan of correction within the required time frame, fails to submit a timely and adequate revised plan of correction, or fails to provide evidence of correction for all cited deficiencies, a recommendation to initiate revocation proceedings must be made to the Commissioner or designee. If the Commissioner or designee approves the initiation of revocation proceedings, the provisions of Subchapter 5 will be followed.

**450:1-9-7.3. Additional certification procedures**

(a) The following conditions will apply to site visits and other related certification reviews conducted by ODMHSAS.

(1) Initial, renewal or follow-up site reviews, based on the current certification status of the applicant, will be scheduled and conducted by designated representatives of the ODMHSAS at each location or site of the applicant.

(2) ODMHSAS may require materials be submitted to Provider Certification, in a form determined by ODMHSAS, prior to on-site visits to verify compliance with one

or more applicable Core Organizational Standards, Core Operational Standards, and/or Quality Clinical Standards.

(3) One or more site review(s) may be conducted to determine compliance with prior deficiencies as well as with standards not applicable during the prior certification visit(s).

(4) A minimum number of ~~five (5)~~ consumer records, as determined by ODMHSAS, shall be made available for review to determine compliance with applicable Quality Clinical Standards. For organizations, unable to provide the required~~a~~ minimum of ~~five (5)~~ records, the current certification status, including a Permit for Temporary Operations, will be allowed to expire. ODMHSAS may require review of additional consumer records to assure a representative sample of records is evaluated to determine compliance with Quality Clinical Standards.

(5) A Site Review Protocol shall be completed during each certification review. Protocols shall contain the current ODMHSAS Standards and Criteria applicable to the facility.

(A) A facility must be prepared to provide evidence of compliance with each applicable standard.

(B) In the event the reviewer(s) identifies some aspect of facility operation that adversely affects consumer safety or health, the reviewer(s) shall notify the facility director and appropriate ODMHSAS staff. An immediate suspension of certification may be made by the Commissioner of ODMHSAS.

(b) **Accreditation status.** The ODMHSAS may accept accreditation granted by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children, Inc. (COA), or the American Osteopathic Association (AOA) as compliance with certain specific ODMHSAS standards. For such to be considered, the facility shall make application and submit evidence to the ODMHSAS of current accreditation status. This evidence shall include documentation of the program or programs included in the most recent accreditation survey, including survey reports of all visits by the accrediting organization, any reports of subsequent actions initiated by the accrediting organization, any plans of correction, and the dates for which the accreditation has been granted.

(c) **Deficiencies.** A deficiency shall be cited for each rule not met by the facility.

(d) **Report to applicant and plan of correction.**

(1) During the course of the certification process, and prior to determination of certification status, ODMHSAS staff shall report the results of the certification review to the facility. The facility shall receive written notice of the deficiencies in a Certification Reportin accordance with 450:1-9-7, 450:1-9-7.1, and 450:1-9-7.3.

(2) The facility may be required to submit a written plan of correction as determined by 450:1-9-7, 450:1-9-7.1, and 450:1-9-7.3. Approval of the plan of correction by Provider Certification may be required before a recommendation for certification can be presented to ODMHSAS or the Board.

(3) If a request for a revised plan of correction is necessary, the facility must submit an acceptable plan of correction within the required time frame to continue the certification process. Failure to submit a timely and adequate revised plan of correction shall result in either a notice of denial of the application, expiration of certification, or revocation of the certification status, as applicable.

(e) **Notification of Departmental recommendation for certification.**

(1) After consideration of materials requested by ODMHSAS pursuant to certification procedures, and completion of the necessary review(s), ODMHSAS staff shall prepare a recommendation on the certification status or application.

(2) Recommendations regarding applications for Permit for Temporary Operations will be forwarded to the ODMHSAS Board, the Commissioner, or designee.

(3) Recommendations for all other Certification applications will be forwarded to the ODMHSAS Board for consideration or in accordance with procedures outlined in 450:21, 450:22, or 450;50.

(4) Prior to the ODMHSAS staff's presentation of its recommendation of an applicant's certification to the Board or the Commissioner or designee the ODMHSAS staff shall notify the applicant of:

(A) the recommendation, and

(B) the date and time of the Board meeting at which the facility's application, and the recommended certification will be presented.

(5) Achievement of certain scores is a prerequisite for consideration of a specific certification status but may not be the sole determinant. Individual deficiencies that meet the criteria in 450:1-9-9 may be grounds for suspending or revoking certification or denying applications for certification.

(6) Consideration of certification may be deferred while additional information regarding a facility's compliance status is reviewed.

(7) The minimum conditions for compliance that must be verified by ODMHSAS for recommendation of a certification status shall be stipulated in 450:1-9-5.1.

(f) **Recommendations for revocation of certification.** In the event ODMHSAS can not recommend certification in accordance with 450:1-9-5.1, except for Permits for Temporary Operations, ODMHSAS shall forward recommendation for revocation of certification to the Commissioner or designee. If the Commissioner or designee approves a recommendation to revoke certification, an individual proceeding shall be initiated pursuant to Subchapter 5. Applicants unable to demonstrate compliance with standards required for Permit for Temporary Operation are not subject to the provisions for revocation and are simply denied the Permit as stipulated in 450:1-9-7.

**450:1-9-7.4. Actions on Non-Certified Providers.**

If at the initial site review it is found the facility is providing services prior to the granting of an ODMHSAS certification status, applicable for those services being provided and in violation of statutory requirements, including prior to the granting

of a Permit for Temporary Operations, the following actions will be taken:

(1) The review will be continued and will include a review of all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards.

(2) The facility must comply with the requirements cited in 450:1-9-5. to continue the certification process. An organization providing services statutorily subject to ODMHSAS Certification prior to the issuance of a Permit for Temporary Operations cannot be recommended for a Permit for Temporary Operations specific to those services. Such organizations are eligible only for a recommendation of Probationary Certification.

(3) The applicant must comply within twenty (20) working days of the initial certification visit, with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards for a recommendation of Probationary Certification to be made to the Board. Failure to achieve the required compliance level for Probationary Certification shall result in a denial for Certification and an Order issued to cease the provision of services, if applicable.

(4) If the applicant achieves the required compliance level within the required time frame, a recommendation of Probationary Certification ~~will~~ may be recommended for no more than one (1) year.

(5) Continued certification after the Probationary Certification period of one year will require the submission of a new application for each of the next two (2) years. The requirements in 450:1-9-5.1(a)(3)shall apply. If the applicant achieves the required compliance level within the required time frame, a recommendation for Probationary Certification for no more than one (1) year will be made to the Board for each of the next two years.

**450:1-9-8.1. Site reviews**

ODMHSAS may conduct a site review or visit or an investigation, which may or may not be unannounced. Reasons for such review include but are not limited to:

(1) verification of continued compliance with Standards and Criteria and related regulations;

(~~1~~2) determination of correction of cited deficiencies;

(~~2~~3) receipt of a complaint;

(~~3~~4) change in ownership, management or location;

(~~4~~5) substantial change in either the service provided or new service(s) initiated;

(~~5~~6) substantial turnover in staff at the executive or professional level;

(~~6~~7) change in statutorily required licensure status; and

(~~7~~8) change in external accreditation status.

**450:1-9-9. Bases for a decision to issue administrative sanction of suspension, or revocation**

(a) A determination that the certification status shall be reduced, suspended, or revoked or that a reprimand be issued, may be made upon the following bases:

(1) failure to comply with certification standards;

(2) failure to comply with appropriate statutory licensing provisions;

(3) violation of consumer rights or consumer confidentiality;

(4) endangerment of the safety, health, and/or the physical or mental well-being of a consumer served by the program;

(5) failure to comply with accreditation, inspection, safety, or building code regulations required by local, state, or federal authorities and laws;

(6) defrauding a consumer, potential consumer, or third party payer;

(7) inappropriate conduct by program staff or its governing authority;

(8) utilization of treatment techniques which endanger the safety, health, and mental health or physical well-being of program consumers; ~~or~~

(9) refusal of access to a facility or any program components by ODMHSAS personnel when conducting announced or unannounced site visits pursuant to this Chapter; or

(10) any other just cause.

(b) Determinations to initiate ~~proceedings for suspension, reduction,~~suspensions, reductions and revocations or to issue reprimands are made by the Commissioner or designee of ODMHSAS.

(c) The facility's certification status continues unless the facility fails to timely file a written request for a hearing as cited in OAC450:1-5-5 or an order sustaining the allegations made by ODMHSAS is issued by the appointed Hearing Officer.

*[OAR Docket #13-880; filed 5-22-13]*

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## TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
## CHAPTER 15. CONSUMER RIGHTS

*[OAR Docket #13-881]*

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 1. General Provisions
450:15-1-2. [AMENDED]
Subchapter 3. Consumer rights
Part 1. Mental Health And Drug or Alcohol Abuse Services Consumer Bill of Rights
450:15-3-3. [AMENDED]
450:15-3-8. [AMENDED]
450:15-3-27. [AMENDED]
Part 11. Resident Rights, Mental Health Residential Care Facilities
450:15-3-81. [AMENDED]
Subchapter 7. Office of consumer advocacy and department investigations

Part 1. Office of Consumer Advocacy
450:15-7-4. [AMENDED]
Part 2. Investigations
450:15-7-6. [AMENDED]
450:15-7-7. [AMENDED]
450:15-7-9. [AMENDED]
450:15-7-14. [AMENDED]
450:15-7-15. AMENDED]

**AUTHORITY:**
Oklahoma Department of Mental Health and Substance Abuse Services Board; 43A O.S. §§ 2-101, 2-108 and 2-109.

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N/A

**INCORPORATIONS BY REFERENCE:**
N/A

**ANALYSIS:**
In accordance with the Administrative Procedures Act the proposed rule revisions to Chapter 15 are part of the Department's review of Title 450. The proposed rules clarify existing rules and are intended to comply with statutory changes.

In an effort to provide increased clarity and uniformity, Chapter 15 proposed changes have been made throughout to further clarify terms used and to reflect terms that are more current, and additional language has been proposed to further clarify rights afforded consumers who are receiving services. Several of the proposed changes are to the "Synopsis of Rights" that must be posted by a provider. These changes are for clarification and for consistency with the enumerated rights already contained in the chapter. Additional proposed changes include reorganization of clarification of the roles of the Office of Consumer Advocacy, the Consumer Advocate General, and the Office of Inspector General.

**CONTACT PERSON:**
Gretchen Geis, Administrative Rules Liaison, Department of Mental Health and Substance Abuse Services, Post Office Box 53277, Oklahoma City, Oklahoma 73152-3277, (405) 522-2053.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

### 450:15-1-2. Definitions

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

**"Abuse"** means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a consumer by staff responsible for the consumer's health, safety, or welfare, including but not limited to:

(A) non-accidental physical injury or mental anguish;
(B) sexual abuse;
(C) sexual exploitation;
(D) use of mechanical restraints without proper authority;
(E) the intentional use of excessive or unauthorized force aimed at hurting or injuring the consumer; ~~or~~
(F) deprivation of food, clothing, shelter, or healthcare by staff responsible for providing these services to a consumer; or
(G) verbal abuse.

**"Advocate"** means an employee of the Office of Consumer Advocacy, who provides assistance to consumers in exercising their rights, listens to their concerns, encourages them to speak for themselves, seeks to resolve problems, helps protect their rights, and seeks to improve the quality of the consumer's life and care.

**"Advocate General"** means the chief administrative officer of the ODMHSAS Office of Consumer Advocacy.

**"Board"** means Board of Mental Health and Substance Abuse Services.

**"Community mental health center"** or **"CMHC"** means a facility offering a comprehensive array of community-based mental health services, including but not limited to, inpatient treatment, outpatient treatment, partial hospitalization, emergency care, consultation and education; and, certain services at the option of the center, including, but not limited to, prescreening, rehabilitation services, pre-care and aftercare, training programs, and research and evaluation.

**"Consumer"** means an individual, adult or child, who has applied for, is receiving or has received mental health or substance abuse evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS ~~contacts~~contracts.

**"Consumer committee"** or **" Consumer government"** means any established group within the facility comprised of consumers, led by consumers and which meets regularly to address consumer concerns to support the overall operations of the facility.

**"Correctional institution"** means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house or residential community program operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense, or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions

through the criminal justice system, witnesses, or others awaiting charges or trial.

**"Crisis stabilization"** means emergency, psychiatric, and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment, and, if needed, referral to an ODMHSAS certified facility having nursing and medical support available.

**"Comprehensive Basis of Accounting"** means a system of accounting other than GAAP, including but not limited to statutory basis, cash basis, or tax basis.

**"Department"** or **"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse services.

**"Designated record set"** means health information, in any medium including paper, oral, video, electronic, film, audio and digital, maintained by or for facilities operated by ODMHSAS for the purpose, in whole or in part, for making decisions about a consumer, that is:

(A) The medical records about a consumer including but not limited to the intake, screenings, assessments, history and physical examination, psychosocial evaluation, consultation report(s), treatment and continuing care plan, medication record(s), progress notes, psychometric/psychological testing results, discharge assessment, discharge plan, discharge summary, physician orders, immunization record(s), laboratory reports, ancillary therapy notes and reports, and case management records; or

(B) The eligibility, billing and payment information and minimum data sets maintained by or for the facility.

(C) Records that are sometimes filed with the medical records but are not part of the designated record set include:

(i) Administrative records including court commitment paperwork, critical incident reports or peer review documents; and

(ii) Information compiled in anticipation of litigation.

**"Emergency detention"** means the detention of a person who appears to be a person requiring treatment in a facility approved by the Commissioner of Mental Health and Substance Abuse Services as appropriate for such detention after the completion of an emergency examination and a determination that emergency detention is warranted for a period not to exceed one hundred twenty (120) hours, excluding weekends and holidays, except upon a court order authorizing detention beyond a one hundred twenty-hour period or pending the hearing on a petition requesting involuntary commitment or treatment as provided by 43A of the Oklahoma Statutes.

**"Emergency examination"** means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted, by a licensed mental health professional to determine if emergency detention of the person is warranted.

**"Exploitation"** or **"exploit"** means an unjust or improper use of the resources of a consumer for the profit or advantage, pecuniary or otherwise, of a person other than the consumer through the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense.

**"Facility"** means a public or private agency, corporation, partnership, or other entity operated or certified by ODMHSAS or with which ODMHSAS contracts to provide the physical custody, detention or treatment of consumers.

**"Generally Acceptable Accounting Principles"** or **"GAAP"** means the authoritative set of accounting principles, standards, and procedures.

**"Guardian"** means a person appointed by a court to ensure the essential requirements for the health and safety of an incapacitated or partially incapacitated person. As used in this subchapter, guardian includes a general or limited guardian of the person, a general or limited guardian of the estate, a special guardian, and a temporary guardian.

**"Licensed mental health professional" or "LMHP"** as defined in Title 43A §1-103 (11).

**"Maltreatment"** is used collectively in this Subchapter to refer to abuse, neglect, exploitation, mistreatment, sexual abuse or exploitation, verbal abuse, and rights violation.

**"Minor"** means any person under the age of 18 years except any person convicted of a crime specified in Section 7306-1.1 of Title 10 of the Oklahoma Statutes or any person who has been certified as an adult pursuant to Section 7303-4.3 of Title 10 and convicted of a felony.

**"Mistreatment"** means an act or omission that results in or creates an unreasonable risk of harm to a consumer and that also:

(A) violates a statute, regulation, written rule, policy, procedure, directive, or accepted professional standards and practices; or

(B) unintentional excessive or unauthorized use of force.

**"Money"** means any legal tender, note, draft, certificate of deposit, stock, bond, check or credit card.

**"Neglect"** means:

(A) the failure of staff to provide adequate food, clothing, shelter, medical care or supervision which includes, but is not limited to, lack of appropriate supervision that results in harm to a consumer;

(B) the failure of staff to provide special care made necessary by the physical or mental condition of the consumer;

(C) the knowing failure of staff to provide protection for a consumer who is unable to protect his or her own interest; or

(D) staff knowingly causing or permitting harm or threatened harm through action or inaction that has resulted or may result in physical or mental injury.

**"Oklahoma Administrative Code"** or **"OAC"** means the publication authorized by 75 O.S. §256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. §256(A)(1)(a) and maintained in the Office of Administrative Rules.

**"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"Program of Assertive Community Treatment"** or **"PACT"** is a clinical program that provides continuous treatment, rehabilitation, and support services to persons with mental illness in settings that are natural to the consumer.

**"Privacy Officer"** means the employee of ODMHSAS designated to provide guidance on state and federal privacy laws.

**"Program"** means a structured set of activities designed and structured to achieve specific objectives relative to the needs of the clients.

**"Resident"** means a person residing in a residential care facility certified by ODMHSAS.

**"Resident committee"** or **"Resident government"** means any established group within the facility comprised of residents, led by residents and which meets regularly to address resident concerns to support the overall operations of the facility.

**"Residential care facility"** or **"RCF"** means any house, home, establishment or institution licensed pursuant to the provisions of the Oklahoma Residential Care Home Act 63 O.S., §§1-819 through 1-840, other than a hotel, fraternity or sorority house, or college or university dormitory, which is certified pursuant to 43 O.S. §3-315 as a Community Residential Mental Health Facility and offers or provides residential accommodations, food service and supportive assistance to its residents or houses any resident requiring supportive assistance that are ambulatory, essentially capable of managing their own affairs and not routinely requiring nursing care or intermediate care.

**"Restraint"** refers to manual, mechanical and chemical methods that are intended to restrict the movement or normal functioning of a portion of an individual's body.

**"Seclusion"** means the placement of an individual or individuals alone in a room or other area from which egress is prevented by a physical barrier, or some other means.

**"Sexual abuse"** includes:

(A) rape, incest, or lewd and indecent acts or proposals, as defined by state law, by staff;

(B) oral, anal or vaginal penetration of a consumer by staff;

(C) the anal or vaginal penetration of a consumer by staff with any other object; or

(D) for the purpose of sexual gratification, the touch, feeling or observation of the body or private parts of a consumer by staff; or

(E) indecent exposure by staff providing services to the consumer.

**"Sexual exploitation"** by staffwith regard to a consumer includes:

(A) staff allowing, permitting or encouraging a consumer to engage in sexual acts with others or prostitution, as defined by state law, which results in harm to a consumer; or

(B) staff allowing, permitting, encouraging, or engaging in the lewd, obscene or pornographic photographing, filming or depicting of a consumer in those acts as defined by state law.

**"Staff"** means an agent or employee of a public or private institution or facility responsible for the care of a client or consumer and providing services to the client or consumer.

**"Treatment Advocate"** is a family member or other concerned individual designated by a consumer to participate in treatment and discharge planning, and acts in the best interest of and serves as an advocate for the consumer.

**"Verbal Abuse"** means the use of words, sounds, or other communication including, but not limited to, gestures, actions or behaviors by staff that are likely to cause a reasonable person to experience humiliation, intimidation, fear, shame or degradation.

## SUBCHAPTER 3. CONSUMER RIGHTS

## PART 1. MENTAL HEALTH AND DRUG OR ALCOHOL ABUSE SERVICES CONSUMER BILL OF RIGHTS

### 450:15-3-3. Notification of the Bill of Rights

(a) Each consumer, upon admission to a facility or program, shall be notified of rights guaranteed by this Part.

(1) If the consumer is a minor, his parent or legal guardian shall also be informed.

(2) If the consumer has a court ordered guardian, the guardian shall be informed.

(b) Notification shall be accomplished by:

(1) Providing the consumer with a synopsis, as set forth in OAC 450:15-3-27 and, if requested, the full Mental Health and Drug or Alcohol Abuse Services Bill of Rights, OAC 450:15-3-6 through 450:15-3-25. If the consumer cannot understand the language in the synopsis, an oral explanation of the synopsis shall be given in a language the person can understand; and the provision of the Mental Health and Drug or Alcohol Abuse Services Bill of Rights shall be documented in the consumer's record and signed by the person giving the synopsis or explanation; and

(2) Posting the synopsis of, or the full Mental Health and Drug or Alcohol Abuse Services Bill of Rights, in a conspicuous place in each consumer living area, and in area(s) of the facility receiving consumers, visitors and the public.

(c) Facilities shall not have internal operating procedures more restrictive than the Mental Health and Drug or Alcohol Abuse Services Bill of Rights. Every consumer shall be notified of facility and unit procedures with which he or she is expected to comply, and consequences for non-compliance.

(d) Employees and volunteers shall be oriented regarding consumers' rights and the constraints of this Part.

(e) Adherence or compliance with all rights in this Chapter shall be demonstrated through review of policies, procedures, actions, and day to day operations of a facility.

**450:15-3-8. Right to freedom from maltreatment**

(a) Staff shall not mistreat, ~~physically, sexually, verbally~~maltreat, or otherwise abuse or neglect any consumer. Visitors or other consumers shall not be permitted to ~~physically, sexually, verbally~~mistreat, maltreat or otherwise abuse or neglect any consumer. ~~Staff shall not neglect any consumer.~~

(b) The facility director shall ensure a critical incident report is completed for each alleged occurrence of abuse or neglect and a copy is forwarded to the ODMHSAS division that is designated to review or investigate allegations of mistreatment, abuse or neglect.

(c) In cases of sexual or physical abuse, the person in charge of the facility shall promptly inform the County Sheriff or the District Attorney so that a criminal investigation can be initiated.

**450:15-3-27. ~~*Synopsis of the bill of rights*~~Synopsis of the bill of rights**

(a) The synopsis in (b) of this Section shall be used when an abbreviated format of OAC 450:15-3-6 through 450:15-3-25 is used to supply a consumer or others with an overview of the bill of rights. The Synopsis of the bill of rights shall not substitute for, or replace a facility's obligation to abide by the full listing of rights cited in this Title. A copy of the synopsis shall be prominently posted in each consumer treatment unit and in consumer admissions, visiting and public areas.

(b) Facilities with physical custody of a consumer or where consumers remain for round-the-clock support or care, or where the facility has immediate control over the setting where a consumer resides, shall support and protect the fundamental human, civil, and constitutional rights of the individual consumer. Each consumer has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights as listed below.

(1) Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

(2) Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition, or sexual orientation.

(3) Each consumer, on admission, shall have the absolute right to private uncensored communication with ~~a relative, friend, clergy, or attorney~~persons of his/her choice by phone or mail, at the facility's expense if the consumer is indigent, and by personal visit.

(4) Each consumer retains the right of confidential communication with persons of his/her choice. A consumer's right to contact the ODMHSAS Advocate's Office, Inspector General's Office, their attorney, personal physician, or clergy shall not be limited by the facility.

(5) Each consumer is entitled to uncensored private communication (letter, telephone, personal visits); such letters or copies of letters shall not be kept in consumer treatment records.

(6) No consumer shall be ~~neglected or sexually, physically, verbally, or otherwise abused~~subject to maltreatment or otherwise abused by staff, visitors, or other consumers.

(7) Each consumer shall receive treatment in the least restrictive environment and have the maximum freedom of movement consistent with his or her clinical condition and legal status.

(8) Each consumer shall have easy access to his or her personal funds deposited with the finance office, and shall be entitled to an accounting. ~~A limitation on access to funds may be made when it is determined by the facility's director to be necessary and essential to prevent the consumer from unreasonably and significantly dissipating his or her assets.~~

(9) Each consumer may have his or her own clothing and other personal possessions. ~~This right can be forfeited if the property is potentially dangerous to the consumer, others, or if the property is functionally unsafe.~~

(10) Each consumer shall have the right to practice his or her religious belief and be accorded the opportunity for religious worship. No consumer shall be coerced into engaging in or refraining from any religious activity, practice, or belief.

(11) Each consumer legally entitled to vote shall be assisted to register and vote when they so request.

(12) Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. ~~If the consumer permits, family shall be involved.~~ Additionally, each consumer shall have the right to the following:

(A) Allow the guardian of the consumer and/or another individual of the consumer's choice to participate in the consumer's treatment and with the consumer's consent;

(B) To be free from unnecessary, inappropriate, or excessive treatment;

(C) To participate in consumer's own treatment planning;

(D) To receive treatment for co-occurring disorders if present;

(E) To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and

(F) To not be discharged for displaying symptoms of the consumer's disorder.

(13) Every consumer's record shall be treated in a confidential manner.

(14) No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

(15) A consumer may voluntarily participate in work therapy and must be paid fair compensation. However,

each consumer is responsible for personal housekeeping tasks without compensation.

(16) A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

(17) Consumer shall be permitted to establish and participate in a consumer committee or consumer government by unit or facility wide.

(18) A consumer being discharged shall have plans for outpatient treatment, sufficient medication, suitable clothing for the season, housing information and referral, and if consumer permits, family involvement in the plan.

(19) Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

(20) No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

(21) Most rights may be limited by the treatment team for therapeutic reasons, including safety of the consumer or other consumers and staff in the facility. These limitations must be documented in the clinical record, reviewed frequently, and shall not be limited for purposes of punishment, staff convenience, or in retaliation for a consumer exercising any of his/her rights.

(c) Programs providing treatment or services without the physical custody or where consumers do not remain for round-the-clock support or care, or where the facility does not have immediate control over the setting where a consumer resides, shall support and protect the fundamental human, civil, and constitutional rights of the individual consumer. Each consumer has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights as listed below.

(1) Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

(2) Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.

(3) No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.

(4) Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. ~~If the consumer permits, family shall be involved.~~Additionally, each consumer shall have the right to the following:

(A) Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;

(B) To be free from unnecessary, inappropriate, or excessive treatment;

(C) To participate in consumer's own treatment planning;

(D) To receive treatment for co-occurring disorders if present;

(E) To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and

(F) To not be discharged for displaying symptoms of the consumer's disorder.

(5) Every consumer's record shall be treated in a confidential manner.

(6) No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

(7) A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

(8) Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

(9) No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

(d) Each affected facility and program shall have written policy and implementing procedures, and shall provide documented staff training to insure the implementation of each and every consumer right stated in this ~~section~~Chapter.

(e) Each affected facility and program shall have written policy and implementing procedures to insure each consumer enjoys, and has explained to him or her, these rights, and these rights are visibly posted in both consumer and public areas of the facility.

(f) The ODMHSAS Office of Consumer Advocacy and the ODMHSAS Office of the Inspector General, in any investigation or monitoring shall have access to consumer, facility or program records and staff as set forth in ~~OAC 450:15-7-3~~this Chapter.

(g) All facilities that are certified by, operated by, or contracted with the Department shall post the contact information for the ODMHSAS Office of Inspector General and ODMHSAS Office of Consumer Advocacy prominently in each consumer treatment unit and in consumer admissions, visiting and public areas.

## PART 11. RESIDENT RIGHTS, MENTAL HEALTH RESIDENTIAL CARE FACILITIES

### 450:15-3-81. Resident rights

(a) Each resident shall have and enjoy all constitutional and statutory rights of all citizens of the State of Oklahoma and the United States, unless abridged by due process of law by a court of competent jurisdiction. Each facility shall insure each resident has the rights specified as follows.

(1) Each resident has the right to be treated with respect and dignity. This shall be construed to protect and promote human dignity and respect for individual dignity.
(2) Each resident has the right to a safe, sanitary, and humane living environment.
(3) Each resident has the right to a humane psychological environment protecting them from harm, abuse, and neglect.
(4) Each resident has the right to an environment which provides reasonable privacy, promotes personal dignity, and provides opportunity for the client to improve his or her functioning.
(5) Each resident has the right to receive services suited to his or her condition and needs for treatment without regard to his or her race, religion, gender, ethnic origin, age, degree of disability, handicapping condition, legal status, sexual orientation.
(6) Each resident, on admission, has the absolute right to communicate his or her change of address with a relative, friend, clergy, or attorney, by telephone or mail.
(7) Each resident shall have and retain the right to confidential communication with an attorney, personal physician, the ODMHSAS Office of Consumer Advocacy, the ODMHSAS Office of Inspector General, or clergy. This right shall not be restricted by the facility.
(8) Each resident has the right to uncensored, private communications including, but not limited to, letters, telephone calls, and personal visits. Copies of any personal letter, sent or received, by a resident shall not be kept in his or her clinical record.
(9) No resident shall ever be ~~neglected or sexually, physically, verbally,~~mistreated, maltreated, or otherwise abused by staff, visitors, or other consumers.
(10) Each resident has the right to easy access to his or her personal funds on deposit with the facility, and shall be entitled to an accounting for said funds. ~~A limitation on access to such funds may be made when it is determined, and documented, as essential to prevent the resident from unreasonably and significantly dissipating their assets. Access to these funds and management, accounting, and protection of these funds shall comply with stipulations outlined in OAC 450:15-3-10 and other related state and federal requirements.~~
(11) Each resident has the right to have his or her own clothing and personal possessions. ~~This right may be forfeited, or limited, only if the personal property is determined to be potentially dangerous to the client, or others, or if the property is determined to be functionally unsafe.~~
(12) Each resident shall have the right to practice his or her own religious beliefs, and afforded the opportunity for religious worship. No client shall ever be coerced into engaging in, or refraining from, any personal religious activity, practice, or belief.
(13) The records of each resident shall be treated in a confidential manner.
(14) Each resident has the right to refuse to participate in any research project or medical experiment without informed consent of the resident, as defined by law. A refusal to participate shall not affect the services available to the resident.
(15) A resident may voluntarily participate in work therapy, and shall be paid just compensation for such participation. However, each resident is responsible for personal care and housekeeping tasks without compensation.
(16) The community residential mental health facility shall provide residents who are leaving at the request of the community residential mental health facility all funds and property belonging to him or her at the time of his or her departure.
(17) Each resident shall have the right to establish and to participate in a resident committee or resident government.
(18) Each resident has the right to assert grievances with respect to any alleged infringement of these stated rights of residents, or any other subsequently statutorily granted rights.
(19) No resident shall ever be retaliated against, or subject to, any adverse conditions because of having asserted his or her rights as ~~aforestated~~stated in this ~~section~~Section.
(20) Most rights may be limited by the treatment team for therapeutic reasons, including safety of the consumer or other consumers and staff in the facility. These limitations must be documented in the clinical record, reviewed frequently, and shall not be limited for purposes of punishment, staff convenience, or in retaliation for a consumer exercising any of his/her rights.

(b) Each affected facility shall have written policy and implementing procedures, and shall provide documented staff training to insure the implementation of each and every resident right stated in this section.
(c) Each affected facility shall have written policy and implementing procedures to insure each resident enjoys, and has explained to him or her, these rights; and these rights are visibly posted in both resident and public areas of the facility.
(d) The Department, in any investigation or monitoring shall have access to residents, RCF records and RCF staff as set forth in OAC 450:15-7-3.

## SUBCHAPTER 7. OFFICE OF CONSUMER ADVOCACY AND DEPARTMENT INVESTIGATIONS

## PART 1. OFFICE OF CONSUMER ADVOCACY

### 450:15-7-4. Office of Consumer Advocacy powers and duties

The Advocate General shall assign an Advocate to monitor the care and treatment of individuals receiving services at each facility operated by, certified by or under contract with the ODMHSAS; and to carry out the purpose and duties of the Office of Consumer Advocacy. The Office of Consumer Advocacy shall have the following powers and duties:

(1) To serve as an advocate for consumers and to ensure the highest quality of care to all consumers at facilities operated by, subject to certification by, or under contract with the Department.
(2) If a consumer needs legal counsel, the Advocate shall advise the consumer of his or her right to seek counsel and refer the individual to counsel, if necessary.
(3) To monitor his or her assigned facilities to ensure the facilities have made adequate provisions for the medical care, supervision and safekeeping of all DMHSAS consumers, and to provide a monthly status report, either verbally or in writing, to the facility's executive director regarding these issues.
(4) To access facilities operated by, subject to certification by or under contract with the Department. Reasonable access shall be granted for the purposes of performing activities as necessary to monitor care and treatment provided by such facilities. These visits may be unannounced and or unscheduled as determined by the Department. Reasonable access shall include, but is not limited to, observations, discussions, and face to face meetings with staff and consumers, copies of policies and procedures related to grievances, complaints, consumer care, access to services and safety; and forms and documentation related to Critical Incidents and Sentinel Events.
(5) To access and copy necessary records of individuals receiving services from facilities operated by, subject to certification by or under contract with the Department. Records that are confidential under state and federal law shall be maintained as confidential and not be ~~redisclosed~~re-disclosed by the Office of Consumer Advocacy.
(6) To be proactive in the enforcement of the provisions of the Mental Health and Substance Abuse Consumer Bill of Rights,
(7) To timely report any issue(s) of which the Office of Consumer Advocacy becomes aware that may adversely affect consumer care through the proper chain of command, beginning at the lowest level, in order to timely resolve such issue(s).
(8) To assist consumers in filing grievances,
(9) To assist in transitioning consumers who are committed to the Oklahoma Forensic Center pursuant to 22 O.S. §§1175.1 et seq. to appropriate alternative placements in accordance with ~~22 O.S. §§1175..1.~~22 O.S. §§1175.1 et seq.
(10) To file habeas corpus or writ of mandamus actions on behalf of individuals receiving services from facilities operated by, subject to certification by or under contract with the Department, and appear on their behalf in civil commitment and criminal post-commitment proceedings, and appear on behalf of Department consumers in proceedings for writs of habeas corpus or mandamus.
(11) To monitor and review grievance procedures in facilities operated by, subject to certification by or under contract with the Department.
(12) To assist consumers in filing grievances and to review and take appropriate action to resolve unresolved grievances and allegations of improper treatment of individuals receiving services from facilities operated by the Department.
(13) To be proactive and assist in the overall improvement of behavioral system and service delivery related to consumers.
(14) To coordinate and communicate with local facility advocates on a regular basis regarding consumer rights, advocacy activities, and quality of care issues.
(15) ~~To~~An advocate or designee by the Advocate General shall visit each facility that is operated by, subject to certification by or under contract with the Department at least one (1) time per fiscal year to ensure the facility has made adequate provisions for the medical care, supervision and safekeeping of all ODMHSAS consumers, and to provide a status report, either verbally or in writing, to the facility's executive director regarding the findings of such visit.
(16) To perform other duties as assigned by the Board or Commissioner.

## PART 2. INVESTIGATIONS

**450:15-7-6. Reporting suspected maltreatment**

(a) **Reporting Requirements.** ODMHSAS employees ~~who have reason to believe that maltreatment of a consumer has occurred~~, employees of facilities contracted with ODMHSAS or subject to certification by ODMHSAS who directly witness maltreatment or are informed of maltreatment by a consumer shall report such information to the ODMHSAS Inspector General.~~ This reporting requirement also extends to employees of facilities which contract with or are certified by ODMHSAS.~~ Persons unsure of what to report are directed call the Inspector General at 1-405-522-4058 or 1-877-426-4058. Questions regarding this reporting requirement may also be made by e-mailing: InspectorGeneral@odmhsas.org.
(b) **Method of Reporting.** Any person obligated to report an allegation of maltreatment of consumers~~, including but not limited to suspected abuse, neglect, mistreatment, or exploitation of consumers~~ shall contact the Inspector General in Oklahoma City, Oklahoma by telephone (1-405-522-4058 or 1-877-426-4058) twenty-four (24) hours a day, seven (7) days a week. Reports may also be made by e-mailing: InspectorGeneral@odmhsas.org or by ~~faxing~~submitting a critical incident report to Provider Certification to at (405) 522-0236.
(c) **Posting of Information.** All facilities that are ~~certified~~subject to certification by, operated by, or contracted with the Department shall post the contact information for the ODMHSAS Office of Inspector General and ODMHSAS Office of Consumer Advocacy prominently in each consumer treatment unit and in consumers admissions, visiting and public areas.

**450:15-7-7. Administrator's responsibilities regarding allegations reportable to the Department**

(a) ~~Immediate protection for safety, health, and welfare.~~ If the Department receives an allegation of maltreatment involving a consumer from anyone other than the executive director of the facility or provider responsible for the consumer, the Department will promptly notify the facility executive director of the allegation. If the facility executive director is a witness or is accused of maltreatment, then the Inspector General shall notify the Commissioner's designee of the allegation.

(b) Upon becoming aware of an allegation of maltreatment involving a consumer, the facility administrator, or designee, shall ensure the safety, protection, and needed medical attention of any consumer named in the allegation and other consumers receiving services from the facility or provider.

(c) When criminal activity is alleged the facility executive director, or designee, shall immediately notify the appropriate law enforcement authority.

**450:15-7-9. Investigation procedures**

(a) The Department shall conduct a prompt investigation of the maltreatment allegation and shall be subject to the ODMHSAS Investigations policy. The investigator shall contact the applicable facility executive director, or designee, to arrange for document production, site visits and interviews.

(b) The Department shall have the authority to access facilities operated by, subject to certification by or under contract with the Department. Reasonable access shall be granted for the purposes of conducting investigations of maltreatment of a consumer ~~including, but not limited to abuse, neglect and improper treatment~~, contract enforcement issues, or certification issues. These investigations may be unannounced and or unscheduled as determined by the Department.

(c) The applicable facility executive director, or designee, shall arrange for the investigator to have immediate and direct access to the alleged victim(s) in the report who is still a consumer of the facility. During an investigation, the facility shall provide the investigator access, and copies of all documents requested, related to all employees, consumers or clients, facilities, files and records of any nature that may pertain to the investigation. Denial of access may be grounds for termination of a contract between ODMHSAS and a contractor or revocation, non-renewal or suspension of certification or both.

(d) Interference includes, but is not limited to:

(1) Intimidating, harassing or threatening a party to the investigation;

(2) Retaliation against a consumer or employee for reporting an allegations; or

(3) Denial of investigator access to clients, employees, facilities, witnesses, records or other relevant information as requested by the investigator.

**450:15-7-14. Investigative interviews**

The investigator shall interview or attempt to interview persons known or identified to have information about the maltreatment allegation. If an injury is alleged, the investigator or other appropriate person shall observe and note apparent injuries, and obtain pertinent medical documentation, including photographs. An attorney or other representative of the person being interviewed may attend an interview only as a silent observer with prior permission of the Department.

(1) The Department shall conduct a separate private interview with each alleged victim when available, available witnesses to the alleged maltreatment, and persons who allegedly were directly or indirectly involved in the allegation, persons with knowledge of relevant information, and each individual accused of the maltreatment. When possible, all other witnesses shall be interviewed prior to interviewing the accused individual(s).

(2) The investigator shall ~~tape~~ record interviews. ~~Tape recordings~~Recordings of interviews remain with the Department's investigative file. Investigative files and ~~tape~~ recordings are not public documents due to the confidential and privileged information contained in the interviews.

(3) The investigator shall inform persons interviewed of the investigative process.

(4) The investigator shall verbally inform each accused individual of the allegation(s). The name of the person making the report of the allegation shall not be disclosed.

(5) During the interview with an individual accused of maltreatment of a consumer, the investigator shall provide the individual an opportunity to respond to the allegation(s). Following the initial interview, if the investigator obtains information to which the accused individual did not have an opportunity to respond, the investigator shall conduct another interview with the individual. The investigator shall advise the accused individual of the substance of the new information and provide an opportunity to present a response.

(6) If there is a need to interview a person who is deaf, hard of hearing, or is non-English speaking, the investigator, with the assistance of the Office of Consumer Advocacy, shall arrange oral or sign language interpreter services by an independent and qualified interpreter.

(7) To schedule an interview with an accused individual, the investigator shall contact the executive director of the facility, or designee, or provider that employs the accused individual. If a reasonable time has passed without being able to schedule an interview, the investigator shall contact the executive director of the facility, or designee, or provider to request the employee be required to participate. If the accused individual refuses to participate in the investigation, the report shall be completed without the accused individual's statement and a finding shall be made based on available information. For other persons needing to be interviewed, the investigator shall follow the same.

(8) If a person fails to appear for a scheduled interview without good cause, the investigator shall complete the investigative report without interviewing that person. The investigative report shall include an explanation of why the interview was not conducted, including documentation of efforts to interview the person.

**450:15-7-15. Investigative report and findings**

(a) After completing the information-gathering portion of the investigative process, the investigator shall prepare a written investigative report minimally containing:

(1) The allegation(s) made to the Department, the location of the alleged incident(s), and the assigned case number;

(2) A statement of any injuries sustained by the alleged victim(s);

(3) The applicable definition(s) of the type of maltreatment at issue such as abuse, neglect, exploitation, or mistreatment;

(4) The finding(s) in accordance with subsection (b) of this Section;

(5) ~~A list of the~~The involved parties, their titles and role in the matter, if they were interviewed and, if so, when and if interviewed face to face or by telephone;

(6) The name, address, and telephone numbers of any interpreter used during the investigation;

(7) An explanation of the basis for the finding(s);

(8) Any areas of concern relating to the referral identified during the investigation regarding that facility, that provider, or practices or procedures which have implications for the safety, health, or welfare of clients;

(9) A list of relevant documents and records reviewed during the investigation; and

(10) A list of attachments to the report.

(b) The investigative finding options are:

(1) **"Supported"** which means the available information establishes that it is more likely than not that the alleged ~~abuse, neglect, or mistreatment~~maltreatment occurred;

(2) **"Unsupported"** which means the available information established that it is unlikely that the alleged ~~abuse, neglect, or mistreatment~~maltreatment occurred; or

(3) **"Inconclusive"** which means the available information was not sufficient to establish whether or not the alleged ~~abuse, neglect, or mistreatment~~maltreatment occurred.

(c) Except as otherwise specifically provided in this section and as otherwise provided by state or federal laws, the information, records, materials and reports related to investigations by the Department are confidential and contain privileged information. Accordingly, such records, materials and reports shall not be open to public inspection nor their contents disclosed nor shall a subpoena or subpoena duces tecum purporting to compel disclosure of such information be valid pursuant to 43A O.S. §1-109(C).

(d) An order of the court authorizing the inspection, release or disclosure of information, records, material and reports related to investigations by the Department shall be entered by a court only after a review of the records and a determination, with due regard for confidentiality of the information and records and the privilege of the persons identified in the records that a compelling reason exists, any applicable privilege has been waived and such inspection, release or disclosure is necessary for the protection of a legitimate public or private interest.

(e) The Department shall provide results of investigations as follows:

(1) A copy of the final investigative report shall be sent to the Commissioner, designated Deputy Commissioner, the Chief Operating Officer, the General Counsel and the executive director of the appropriate ODMHSAS operated facility.

(2) When an executive director of a facility that is operated by the Department is named as an individual accused of maltreatment of a consumer in the allegation, the final report will not be forwarded to that individual.

(3) A summary of the allegation and finding shall be sent to the executive director of a facility that is subject to certification by or under contract with the Department.

(4) When an executive director of a facility that is subject to certification by or under contract with the Department is named as an individual accused of maltreatment of a consumer in the allegation, a summary of the investigative report shall not be forwarded to that individual, and the investigator shall forward a summary of the investigative report to the chair of the board of directors of the facility.

(5) A summary of the allegations and finding shall be provided to the Board and a copy of the report shall be provided upon request of the Board.

(6) The Department shall notify individuals of the Department's findings as laid out in the Department's Investigations Policy.

(7) Upon request, the Department may summarize the outcome of an investigation, stating the allegation and the finding. The summary may be provided to the person suspected of the ~~abuse, neglect or improper treatment~~maltreatment, the person subject to alleged ~~abuse, neglect or improper treatment~~maltreatment, the person who reported an allegation and the executive director of a facility certified by or under contract with the Department at which the alleged ~~abuse, neglect, or improper treatment~~maltreatment occurred.

(f) The Department shall maintain the original report, supporting documents, and pertinent recorded tapes in locked file cabinets in accordance with the applicable ODMHSAS records management and disposition plan.

*[OAR Docket #13-881; filed 05-22-13]*

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## TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
## CHAPTER 17. STANDARDS AND CRITERIA FOR COMMUNITY MENTAL HEALTH CENTERS

*[OAR Docket #13-882]*

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 1. General Provisions
450:17-1-2. [AMENDED]

Subchapter 3. Required Services
Part 7. Outpatient Therapy Services
450:17-3-61. [AMENDED]
Part 21. Peer Support Services
450:17-3-191. [AMENDED]
450:17-3-192. [AMENDED]
450:17-3-193. [AMENDED]

**AUTHORITY:**
Oklahoma Department of Mental Health and Substance Abuse Services Board; 43A O.S. §§ 2-101, 3-306, 3-306.1 and 3-315; 74 O.S. §85.9G.

**DATES:**
**Comment period:**
February 2, 2013 thru March 5, 2013
**Public hearing:**
March 8, 2013
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March 22, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
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March 22, 2013
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April 29, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 17, 2013
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May 17, 2013
**Effective:**
July 1, 2013

**SUPERSEDED EMERGENCY ACTIONS:**
N/A

**INCORPORATIONS BY REFERENCE:**
N/A

**ANALYSIS:**
Community Mental Health Center rules are revised to update terms and definitions in order to comply with changes made to Oklahoma Health Care Authority rules found in Title 317 of the Oklahoma Administrative Code. Additional proposed changes are made to provide increased clarity and uniformity.

**CONTACT PERSON:**
Gretchen Geis, Administrative Rules Liaison, Department of Mental Health and Substance Abuse Services, Post Office Box 53277, Oklahoma City, Oklahoma 73152-3277, (405) 522-2053.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

### 450:17-1-2. Definitions

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

**"Abuse"** means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a consumer by a staff responsible for the consumer's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a consumer.

**"Adults who have a serious mental illness"**~~are~~means persons eighteen (18) years of age or older who ~~meet the following criteria~~show evidence of points of (A), (B) and (C) below:

~~(A) Currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet criteria specified within DSM IV with the exception of "V" codes, substance abuse disorders, and developmental disorders, unless they co-occur with another diagnosable serious mental illness; and~~

~~(B) Based on a client assessment scale, has moderate impairment in at least four, severe impairment in two or extreme impairment in one of the following areas:~~

~~(i) Feeling, mood and affect;~~
~~(ii) Thinking;~~
~~(iii) Family relationships;~~
~~(iv) Interpersonal skills;~~
~~(v) Role performance;~~
~~(vi) Socio-legal; or~~
~~(vii) Self-care and basic needs; or~~

~~(C) Has duration of illness of at least one year and at least moderate impairment in two, or severe impairment in one of the following areas:~~

~~(i) Feeling, mood and affect;~~
~~(ii) Thinking;~~
~~(iii) Family relationships;~~
~~(iv) Interpersonal skills;~~
~~(v) Role performance;~~
~~(vi) Socio-legal; or~~
~~(vii) Self-care and basic needs.~~

(A) The disability must have persisted for six months and be expected to persist for a year or longer.

(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(C) The adult must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations.

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

**"AOA"** means American Osteopathic Accreditation

**"Case management services"** means planned referral, linkage, monitoring and support, and advocacy provided in partnership with a consumer to assist that consumer with self sufficiency and community tenure and take place in the individual's home, in the community, or in the facility, in accordance with a service plan developed with and approved by the consumer and qualified staff.

**"CARF"** means Commission on Accreditation of Rehabilitation Facilities**.**

**"Child with Serious Emotional Disturbance"** or **"SED"** means a child under the age of 18 who ~~meets the following criteria~~shows evidence of points of (A), (B) and (C) below:

~~(A) Currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet criteria specified within DSM IV with the exception of "V" codes, and developmental disorders, unless they co-occur with another diagnosable serious mental illness; and~~

~~(B) Based in a client assessment scale, has moderate impairment in at least four, severe impairment in two or extreme impairment in one of the following areas:~~

~~(i) Feeling, mood and affect;~~
~~(ii) Thinking;~~
~~(iii) Substance use;~~
~~(iv) Family;~~
~~(v) Interpersonal;~~
~~(vi) Role performance;~~
~~(vii) Socio-legal;~~
~~(viii) Self-care and basic needs; or~~
~~(ix) Caregiver resources; or~~

~~(C) Has duration of illness for at least one year and at least moderate impairment in two, or severe impairment in one of the following areas:~~

~~(i) Feeling, mood and affect;~~
~~(ii) Thinking;~~
~~(iii) Substance use;~~
~~(iv) Family;~~
~~(v) Interpersonal;~~
~~(vi) Role performance;~~
~~(vii) Socio-legal;~~
~~(viii) Self-care and basic needs; or~~
~~(ix) Caregiver resources.~~

(A) The disability must have persisted for six months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

**"Chronic Homelessness"** refers to an individual with a disabling condition who has either: (a) been continuously homeless for a year or more, or (b) has had at least 4 episodes of homelessness in the past 3 years. For this condition, the individual must have been on the streets or in an emergency shelter (i.e. not transitional housing) during these episodes. Chronic homelessness only includes single individuals, not families. A disabling condition is a diagnosable substance abuse disorder, serious mental illness, or developmental disability, including the co-occurrence of two or more of these conditions.

**"Clinical privileging"** means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

**"Clubhouse"** means a psychiatric rehabilitation program currently certified as a Clubhouse through the International Center for Clubhouse Development (ICCD).

**"Community living programs"** means either transitional or permanent supported housing for persons not in crisis who need assistance with obtaining and maintaining an independent living situation.

**"Community-based Structured Crisis Center" or "CBSCC"** means a program of non-hospital emergency services for mental health and substance abuse crisis stabilization as authorized by 43A O.S. §3-317, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance abuse services. This service is limited to CMHC's who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

**"Community mental health center"** or **"CMHC"** means a facility offering a comprehensive array of community-based mental health services, including but not limited to, inpatient treatment, outpatient treatment, partial hospitalization, emergency care, consultation and education; and, certain services at the option of the center, including, but not limited to, prescreening, rehabilitation services, pre-care and aftercare, training programs, and research and evaluation.

**"Consumer"** means an individual, adult, adolescent, or child, who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

**"Consumer advocacy"** includes all activities on behalf of the consumer to assist with or facilitate resolution of problems in the acquisition of resources or services needed by the consumer.

**"Consumer committee"** or **"consumer government"** means any established group within the facility comprised of consumers, led by consumers and meets regularly to address consumer concerns to support the overall operations of the facility.

**"Co-occurring disorder" (COD)** means any combination of mental health symptoms and substance abuse symptoms or diagnoses that affect a consumer and are typically determined by the current Diagnostic and Statistical Manual of Mental Disorders.

**"Co-occurring disorder capability"** means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to consumers with co-occurring disorders.

**"Co-occurring disorder enhanced"** means that the program (or subunit of the program) provides a specialized service designed for individuals with co-occurring disorders, usually with a higher level of available service capacity or intensity for the co-occurring substance use disorder than would be the case in a comparable co-occurring disorder capable program.

**"Crisis Diversion"** means an unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community.

**"Crisis Intervention"** means actions taken, and services provided to address emergency psychological, physiological, and safety aspects of alcohol, drug-related, and mental health crises.

**"Crisis stabilization"** means emergency, psychiatric, and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment, and, if needed, referral to an ODMHSAS certified facility having nursing and medical support available.

**"Critical incident"** means an occurrence or set of events inconsistent with the routine operation of a facility, service setting, or otherwise routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff and visitors; medication errors; residential consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

**"Cultural competency"** means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

**"DSM"** means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

**"Emergency detention"** means the detention of a person who appears to be a person requiring treatment in a facility approved by the Commissioner of Mental Health and Substance

Abuse Services as appropriate for such detention after the completion of an emergency examination and a determination that emergency detention is warranted for a period ~~not to exceed seventy two (72) hours, excluding weekends and holidays, except upon a court order authorizing detention beyond a seventy two hour period or pending the hearing on a petition requesting involuntary commitment or treatment~~as provided by 43A of the Oklahoma Statutes.

**"Emergency examination"** means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted by a licensed mental health professional to determine if emergency detention of the person is warranted.

**"Face-To-Face"** for the purposes of the delivery of behavioral health care, means a face-to-face physical contact and in-person encounter between the health care provider and the consumer, including the initial visit. The use of telemedicine shall be considered a face-to-face encounter.

**"Facilities or Facility"** means entities as described in Title 43A O.S. § 1-103(7), community mental health centers, residential mental health facilities, community based structured crisis centers, certified services for the alcohol and drug dependent, programs of assertive community treatment, eating disorder treatment, gambling addiction treatment, and narcotic treatment programs.

**"General psychiatric rehabilitation"** or **"PSR"** means a type of psychiatric rehabilitation program which focuses on long term recovery and maximization of self-sufficiency, role function and independence. General psychiatric rehabilitation programs may be organized within a variety of structures which seek to optimize the participants' potential for occupational achievement, goal setting, skill development and increased quality of life.

**"Historical timeline"** means a method by which a specialized form is used to gather, organize and evaluate information about significant events in a consumer's life, experience with mental illness, and treatment history.

**"Homebased services to children and adolescents"** means intensive therapeutic services provided in the home to children for the purpose of reduction of psychiatric impairment and preventing removal of the child to a more restrictive setting for care. Services include a planned combination of procedures developed by a team of qualified mental health professionals, including a physician.

**"Homeless"** refers to a person who is sleeping in an emergency shelter; sleeping in places not meant for human habitation, such as cars, parks, sidewalks, or abandoned or condemned buildings; spending a short time (30 consecutive days or less) in a hospital or other institution, but ordinarily sleeping in the types of places mentioned above; living in transitional/supportive housing but having come from streets or emergency shelters; being evicted within a week from a private dwelling unit and having no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing; being discharged from an institution and having no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing; or is fleeing a domestic violence situation and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.

**"ICCD"** means the International Center for Clubhouse Development.

**"Independent living skills, assistance in development of"** means all activities directed at assisting individuals in the development of skills necessary to live and function within the community, e.g., cooking, budgeting, meal planning, housecleaning, problem-solving, communication and vocational skills.

~~**"Integrated Client Information System"** or **"ICIS"** is a comprehensive management information system based on national standards for mental health and substance abuse databases. It is a repository of diverse data elements that provide information about organizational concepts, staffing patterns, consumer profiles, program or treatment focus, and many other topics of interest to clinicians, administrators and consumers. It includes unique identifiers for agencies, staff and consumers that provide the ability to monitor the course of consumer services throughout the statewide ODMHSAS network. ICIS collects data from hospitals, community mental health centers, substance abuse agencies, residential care facilities, prevention programs, and centers for the homeless which are operated or funded in part by ODMHSAS.~~

**"Licensed mental health professional"** or **"LMHP"** as defined in Title 43A §1-103(11).

**"Linkage"** refers to the communication and coordination with other service providers to assure timely appropriate referrals between the CMHC and other providers.

**"Medical resident"** means a physician who is a graduate of a school of medicine or osteopathy and who is receiving specialized training in a teaching hospital under physicians who are certified in that specialty.

**"Medication error"** means an error in prescribing, dispensing or administration of medication, regardless if the error reached the consumer, e.g., omission of prescribed drugs, giving drugs not prescribed, prescribing inappropriate drugs, prescribing or administering incorrect dosages, incorrectly filling or labeling prescriptions, incorrectly transcribing medication orders.

**"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"Oklahoma Administrative Code"** or **"OAC"** means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1) (a) and maintained in the Office of Administrative Rules.

**"Performance Improvement"** or **"PI"** means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous quality improvement, continuous improvement, organization-wide quality improvement and total quality management.

**"Permanent supported housing"** means a type of Community Living Program, either permanent scattered site

housing or permanent congregate housing, where consumers are assisted with locating housing of their choice and are offered on-going support services based on need and choice to ensure successful independent living.

**"PICIS System"** means a management information system based on national standards for mental health and substance abuse databases. Information gathered through PICIS is used for prior authorizations, service utilization management and continuous quality improvement processes. PICIS data is reported throughout the treatment episode to ensure service recipients receive appropriate types and levels of care and are making satisfactory progress. Numerous reports are developed using PICIS data and are provided to clinicians, administrators and the general public.

**"Program of Assertive Community Treatment"** or **"PACT"** is a clinical program that provides continuous treatment, rehabilitation, and support services to persons with mental illness in settings that are natural to the consumer.

**"Progress notes"** mean a chronological written description of services provided to a consumer, resident, client, or patient that documents, utilizing acceptable documentation practices, the consumer's response related to the intervention plan or services provided.

**"Psychological-Social evaluations"** are in-person interviews conducted by professionally trained personnel designed to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

**"Psychotherapy"** or **"Therapy"** means a goal directed process using generally accepted clinical approaches provided face-to-face by a qualified service provider with consumers in individual, group or family settings to promote positive emotional or behavioral change.

**"Recovery Support Specialist"** or **"RSS"** means an individual who has completed the ODMHSAS RSS training and has passed the ODMHSAS RSS exam.

**"Rehabilitation Services"** means face-to-face individual or group services provided by qualified staff to develop skill necessary to perform activities of daily living and successful integration into community life.

**"Resident"** means a person residing in a community living program certified by ODMHSAS.

**"Residential treatment"** means a structured, 24-hour supervised treatment program for individuals who are mentally ill with a minimum of twenty-one (21) hours of therapeutic services provided per week with the emphasis on stabilization and rehabilitation for transfer to a less restrictive environment. Stay in the program is time limited.

**"Restraint"** refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of an individual's body.

**"Screening"** means the process to determine whether the person seeking assistance needs further comprehensive assessment.

**"Sentinel event"** is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

**"Service area"** means a geographic area established by the Department of Mental Health and Substance Abuse Services for support of mental health and substance abuse services [43A O.S.§3-302(1)].

**"Service plan"** or **"Treatment plan"** means the document used during the process by which a qualified service provider and the consumer together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

**"Socialization"** means all activities, which encourage interaction and the development of communication, interpersonal, social and recreational skills and can include consumer education.

**"Supportive services"** refers to assistance with the development of problem-solving and decision-making skills to maintain or achieve optimal functioning within the community and can include consumer education.

**"TJC"** means The Joint Commission formerly referred to as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO.

**"Transitional housing program"** means a type of Community Living Program in which the consumer's stay in the residence is considered temporary and time-limited in nature. The actual program model may include a range of approaches, including but not limited to supervised transitional living programs and supervised transitional housing programs.

**"Trauma informed capability"** means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.

**"Vocational assessment services"** means a process utilized to determine the individual's functional work-related abilities and vocational preferences for the purpose of the identification of the skills and environmental supports needed by the individual in order to function more independently in an employment setting, and to determine the nature and intensity of services which may be necessary to obtain and retain employment.

**"Vocational placement services"** means a process of developing or creating an appropriate employment situation matched to the functional abilities and choices of the individual for the purpose of vocational placement. Services may include, but are not limited to, the identification of employment positions, conducting job analysis, matching individuals to specific jobs, and the provision of advocacy with potential employers based on the choice of the individual served.

**"Vocational preparation services"** means services that focus on development of general work behavior for the purpose

of vocational preparation such as the utilization of individual or group work-related activities to assist individuals in understanding the meaning, value and demands of work; to modify or develop positive work attitudes, personal characteristics and work behaviors; to develop functional capacities; and to obtain optimum levels of vocational development.

**"Volunteer"** means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

**"Walk through"** means an exercise in which staff members of a facility walk through the program's treatment processes as a consumer. The goal is to view the agency processes from the consumer's perspective for the purpose of removing barriers andenhancing treatment.

**"Wellness"** means the condition of good physical, mental and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle modifications.

"**Young Adults in Transition"** are persons between sixteen to twenty-five (16-25) years of age who have a serious mental illness, and/or serious emotional disturbance, and meet the following criteria:

(A) Currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet criteria specified within the current version of DSM with the exception of substance abuse disorders and developmental disorders, unless they co-occur with another diagnosable serious mental illness; and

(B) Based on a client assessment scale, (1) moderate impairment in at least four, or (2) severe impairment in at least two, or (3) extreme impairment in one of the following areas:

(i) Feeling, mood and affect;
(ii) Thinking;
(iii) Substance use disorder
(iv) Family and family relationships;
(v) Interpersonal skills; Community life functioning
(vi) Role performance; Social connectedness
(vii) Social
(viii) Self care and basic needs; or
(ix) Caregiver resources; or

(C) Has duration of illness of at least one year and (1) at least moderate impairment in two, or (2) severe impairment in one of the following areas:

(i) Feeling, mood and affect;
(ii) Thinking;
(iii) Family relationships;
(iv) Interpersonal skills; Community life functioning
(v) Role performance; Social connectedness
(vi) Social
(vii) Self Care and basic needs
(viii) Substance use disorder

## SUBCHAPTER 3. REQUIRED SERVICES

## PART 7. OUTPATIENT THERAPY SERVICES

### 450:17-3-61. Outpatient therapy services

(a) Outpatient services shall include a range of co-occurring disorder capable services to consumers based on their needs regarding emotional, social and behavioral problems. These outpatient therapy services shall be provided or arranged for, and shall include, but not be limited to the following:

(1) Individual therapy;
(2) Group therapy;
(3) Family therapy;
(4) Psychological/psychometric evaluations or testing; and
(5) Psychiatric assessments.

(b) Compliance with 450:17-3-61 shall be determined by a review of written policy and procedures; clinical records; and ~~ICIS~~PICIS data reported by facilities.

## PART 21. PEER SUPPORT SERVICES

### 450:17-3-191. Peer support services

(a) Peer support services are provided as a program integrated within the overall structure of Community Mental Health Center services and must be offered to adults age 18 and older with serious mental illnesses, including co-occurring disorders.

(b) Peer support services may be offered to other consumers of the community mental health center and their families.

(c) These services shall

(1) Be based on an individualized, recovery-focused service philosophy that allows individuals the opportunity to learn to manage their own recovery and advocacy process;
(2) Recognize the unique value of services being provided by persons with lived experience who are able to demonstrate their own hopefulness and recovery;
(3) Enhance the development of natural supports, coping skills, and other skills necessary to function as independently as possible in the community, including, but not limited to assisting re-entry into the community after a hospitalization or other institutional settings;
(4) Have written policies specific to these services; and,
(5) Be provided by Peer Recovery Support Specialist(s) as defined by 450:17-3-192.

(d) Each CMHC shall have in place provisions for direct supervision and other supports for staff providing this service.

(e) Compliance with 450:17-3-191 shall be determined by a review of the following: documentation of linkage activities and agreements; clinical records; ~~ICIS~~PICIS reporting data; and, CMHC policy and procedures.

### 450:17-3-192. Peer Recovery Support Specialists staff requirements

(a) Peer Recovery Support Services shall be provided only by staff who are certified as a Peer Recovery Support Specialist pursuant to Oklahoma Administrative Code, Title 450,

Chapter 53 ~~have completed the ODMHSAS RSS training and have passed the ODMHSAS RSS exam~~.

(b) Each CMHC shall ~~document and~~ maintain records to verify certification~~compliance with training and testingrequirements of~~for each provider of this service.

(c) Compliance for 450:17-3-192shall be determined by a review of the facility personnel records and ODMHSAS files.

**450:17-3-193. Peer Recovery Support services: Locale and frequency**

(a) Peer Recovery Support services can be provided in any location. The majority of contacts should be face-to-face, however, services may be provided over the telephone as necessary to help the consumer achieve his/her goals.

(b) Compliance for 450:17-3-193 shall be determined by a review of the agency policy and procedures, ~~ICIS~~PICIS consumer records, consumer interviews, and observation.

*[OAR Docket #13-882; filed 5-22-13]*

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## TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
## CHAPTER 50. STANDARDS AND CRITERIA FOR CERTIFIED BEHAVIORAL HEALTH CASE MANAGERS

*[OAR Docket #13-883]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
450:50-1-2. [AMENDED]
Subchapter 3. Behavioral Health Case Manager Certification Application
450:50-3-1. [AMENDED]
450:50-3-2. [AMENDED]
450:50-3-3. [AMENDED]
450:50-3-7. [AMENDED]
Subchapter 5. Behavioral Health Case Manager Certification Training and Web-Based Competency ~~Exam~~ Exams
450:50-5-1.[AMENDED]
450:50-5-4.[AMENDED]
450:50-5-5. [AMENDED]
Subchapter 7. Rules of Professional Conduct
450:50-7-1. [AMENDED]
450:50-7-3. [AMENDED]
**AUTHORITY:**
Oklahoma Department of Mental Health and Substance Abuse Services Board; 43A O.S. §§ 2-101, 3-306 and 3-318.
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**SUPERSEDED EMERGENCY ACTIONS:**
N/A
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N/A
**ANALYSIS:**
In accordance with the Administrative Procedures Act the proposed rule revisions to Chapter 50 are part of the Department's review of Title 450. The proposed rules clarify existing rules and are intended to comply with statutory changes.

Certified Behavioral Health Case Management rules are revised to enhance the education and training requirements for individuals applying to be certified as a Case Manager II. The scope of CM II's practice will now include psychiatric rehabilitation services so the training and examination requirements will now include a psychiatric rehabilitation component in order to better prepare individuals to provide these services. These proposed revisions create a certification process for individuals designated as Behavioral Health Rehabilitation Specialists (BHRS) and correspond with provider qualification requirements in the Oklahoma Health Care Authority's Administrative rules found in Title 317 of the Oklahoma Administrative Code. Proposed rules also remove the Case Manager III certification, as licensed behavioral health professionals (LBHPs) and Certified Alcohol and Drug Counselors (CADCs) will now be able to provide case management and rehabilitation services pursuant to their respective licensures/certifications and will not be required to obtain certification through ODMHSAS.
**CONTACT PERSON:**
Gretchen Geis, Administrative Rules Liaison, Department of Mental Health and Substance Abuse Services, Post Office Box 53277, Oklahoma City, Oklahoma 73152-3277, (405) 522-2053.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 1. GENERAL PROVISIONS

**450:50-1-2. Definitions**

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

**"Board"** means the State Board of Mental Health and Substance Abuse Services.

**"Case management"** means the application of principles and practices of linking, advocacy and referral in partnership with a consumer to support the consumer in self-sufficiency and community tenure.

**"Certified Behavioral Health Case Manager ~~or CB-HCM~~I (CM I)"** means any person who is certified by the Department of Mental Health and Substance Abuse Services (ODMHSAS) to offer behavioral health case management services ~~as one of the three (3) classifications of case manager within the confines of~~as an employee of a mental health facility or drug or alcohol treatment facility that is operated or certified by the Department or contracts with the State to provide behavioral health services.

**"Certified Behavioral Health Case Manager II (CM II)"** means any person who is certified by ODMHSAS to offer behavioral health case management services and behavioral health rehabilitation services (BHR) as an employee of a mental health facility or drug or alcohol treatment facility that is operated or certified by the Department or contracts with the State to provide behavioral health services.

**"Commissioner"** means the Commissioner of Mental Health and Substance Abuse Services.

**"Consumer"** means an individual who is receiving or has received services

(evaluation or treatment) from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in Title 450, Chapters 16, 17, 18, 19 ~~and~~, 23, and 24 of the Oklahoma Administrative Code as client(s) or patient(s) or resident(s) or a combination thereof.

**"Department"** or **"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"Licensed Behavioral Health Professional" or "LBHP"** means: 1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry. 2) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards: (A) Psychology; (B) Social Work (clinical specialty only); (C) Professional Counselor; (D) Marriage and Family Therapist; (E) Behavioral Practitioner; or (F) Alcohol and Drug Counselor. 3) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided. 4) A Physician Assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

**"Licensed mental health professional"** or **"LMHP"** as defined in Title 43A §1-103 (11).

~~**"Provisionally Certified Behavioral Health Case Manager"** means a person who has met the requirements of the Department's web-based competency exam in behavioral health case management.~~

**"Web-Based Competency Exam"** as prescribed by the Department is a competency exam certain individuals must pass to become ~~provisionally or fully~~ certified as a Behavioral Health Case Manager.

**"36-Months Experience"** means twenty (20) or more hours work or volunteer experience per week over the course of time indicated with persons living with mental illness and/or substance abuse.

## SUBCHAPTER 3. BEHAVIORAL HEALTH CASE MANAGER CERTIFICATION APPLICATION

### 450:50-3-1. Qualifications for certification

(a) Each applicant for certification as a behavioral health case manager shall:

(1) Be currently employed at a mental health facility, or a drug or alcohol treatment facility that is operated by the Department or contracts with the State to provide behavioral health services;

(2) Possess good moral turpitude;

(3) Be at least 21 years of age; and

(4) Otherwise comply with rules promulgated by the Board implementing 43A O. S. § 3-318.

(b) In addition to the qualifications specified by subsection (a) of this rule, an applicant for a certification as a Certified Behavioral Health Case ~~Managers shall possess one of the following~~Manager must meet either (1) or (2) below:

~~(1) Licensed Behavioral Health Professional;~~

~~(2) Any bachelors or masters degree earnWed from a regionally accredited college or university recognized by the United States Department of Education;~~

(1) Certified Behavioral Case Manager II (CM II):

(A) A Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or an education degree earned from a regionally accredited college or university recognized by the United States Department of Education with at least nine (9) hours of college credit in a behavioral health related field; or

(B)~~(3)~~a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; or

~~(4) a current certification as an alcohol and drug counselor in Oklahoma; or~~

(C) a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification as a Certified Psychiatric Rehabilitation Practitioner (CPRP).

(2) Certified Behavioral Health Case Manager I (CM I) must meet the requirements in (A) or (B) below:

(A) 60 college credit hours; or

(B) a high school diploma, or equivalent, from a regionally accredited institution recognized by the United States Department of Education with a total of 36 months of direct, documented experience working with persons who live with mental illness and/or substance abuse issues.

~~(5) Have one of the following qualifications:~~

~~(A) Have completed 60 college credit hours; or~~

~~(B) High school diploma, or equivalent, with 36 total months of direct, documented experience working with persons who live with a mental illness and/or substance abuse issues.~~

### 450:50-3-2. Applications for certification

(a) Applications for certification as a Certified Behavioral Health Case Manager shall be submitted electronically to

the Department on a form and in a manner prescribed by the Commissioner or designee.

(b) ~~An application shall include the following items.~~Depending on the type of CM certification that the applicant is applying for; the application shall include the following items:

~~(1) Application form completed in full according to its instructions;~~

~~(2) Official college or university transcript(s); not required if submitting documentation of current status as a Licensed Behavioral Health Professional in the state of Oklahoma or current licensure as a registered nurse in the state of Oklahoma, or documentation of current certification as an alcohol and drug counselor in Oklahoma;~~

~~(3) Documentation of current status as a Licensed Behavioral Health Professional in the state of Oklahoma or current licensure as a registered nurse in the state of Oklahoma;~~

~~(4) Fees~~

~~(5) Verification of work experience or volunteer experience (if applicable) shall be submitted on a Department approved form only~~

~~(A) The verification form(s) from the employer or volunteer agency must be sent to ODMHSAS by the employer or volunteer agency.~~

~~(B) Volunteer work must be time spent directly with persons who have a mental illness, co-occurring or substance abuse disorder.~~

(1) CM II must include (A), (B) and (E) and one of (C) or (D) as applicable:

(A) Application form completed in full according to its instructions.

(B) Official college or university transcript(s) or an electronic copy submitted to the Department by the college or university.

(C) Documentation of current licensure as a registered nurse in the State of Oklahoma.

(D) Current certification as a CPRP.

(E) Fees.

(2) CM I must include (A), (D) and either (B) or (C):

(A) Application form completed in full according to its instructions.

(B) Official College or university transcript(s) or an electronic copy submitted to the Department by the college or university.

(C) Official high school transcript(s) or an electronic copy submitted to the Department by the high school and verification of work experience or volunteer experience.

(i) Verification shall only be submitted using a Department approved form.

(ii) Verification form(s) must be sent to the Department directly from the employer or volunteer agency.

(iii) Volunteer work must be time spent directly with persons who have a mental illness, co-occurring or substance abuse disorder.

(D) Fees.

(c) ~~A complete~~An application must be submitted ~~at least fourteen (14) days~~ and approved by the Department prior to attending any web-based or face-to-face Certified Behavioral Health Case Manager certification training.

~~(d) Applications shall be submitted and approved by the Department prior to eligibility of taking the case management exam.~~

(~~e~~d) Applications shall only be valid for a period up to six (6) months from the date of application.

(~~f~~e) Applicants shall have no violations of moral turpitude or misconduct as set forth in these rules during time of application process.

(~~g~~f) An applicant, who meets the requirements for certification and otherwise complied with this Chapter, shall be eligible for certification.

**450:50-3-3. Duration of certification**

(a) ~~Certification issued pursuant to this Chapter shall require renewal annually from the year of issuance unless revoked. Certified Behavioral Health Case Managers must renew their certification prior to December 31 of the renewal year and annually thereafter.~~ **Issuance.** ODMHSAS will issue an appropriate certification to all applicants who successfully complete the requirements for certification as specified in this Chapter.

(b) ~~Renewal shall be accomplished by submitting the renewal application, annual report of continuing education units with accompanying documentation, and the renewal fee.~~**Renewal.** Unless revoked, certification issued pursuant to this Chapter must be renewed by June 30 of the calendar year following twelve (12) months of continuous certification and annually thereafter. Renewal is accomplished by submitting:

(1) the renewal application;

(2) annual report of continuing education units with accompanying documentation;

(3) proof of certification or licensure as a CPRP or RN as applicable; and

(4) the renewal fee.

(c) ~~A certification~~**Suspension and Reinstatement.** Certifications not renewed by the ~~December 31~~renewal deadline will be suspended. A suspended certification may be renewed by submitting required fees and documentation of continuing education within six (6) months of the ~~expiration~~ date of suspension. ~~Certificates not renewed within six (6) months will not be reinstated.~~ Certifications not renewed within this six (6) month timeframe will not be reinstated. The individual must then wait a period of sixty (60) days and submit a new application for certification and successfully complete the requirements for initial certification as specified in this Chapter.

~~(d) A certification that was not renewed within the period provided and was not reinstated, must wait a period of sixty (60) days before reapplying and shall submit a new application.~~

**450:50-3-7. ~~Classifications~~Scope of ~~Certified~~ Behavioral Health Case ~~Managers~~Manager Certifications**

~~(a) Certified Behavioral Health Case Manager III: Licensed Behavioral Health Professional;~~

(~~b~~a) Certified Behavioral Health Case Manager II~~: any bachelor's or master's degree earned from a regionally accredited college or university recognized by the United States Department of Education, or a current license as a registered nurse in Oklahoma, or a current certification as an alcohol and drug counselor in Oklahoma; or~~ are authorized to provide behavioral health case management and behavioral health rehabilitation services.

(~~c~~b) Certified Behavioral Health Case Manager I~~: have completed 60 college credit hours; or High school diploma (or equivalent) with 36 total months of experience working with persons who have a mental illness and/or substance abuse issues.~~ are authorized to provide behavioral health case management services.

## SUBCHAPTER 5. BEHAVIORAL HEALTH CASE MANAGER CERTIFICATION TRAINING AND WEB-BASED COMPETENCY ~~EXAM~~ EXAMS

**450:50-5-1. Case management certification training**

(a) The purpose of this section is to delineate the training requirements for each of the ~~three~~ classifications of Certified Behavioral Health Case Managers ~~(CBHCM)~~(CMs).

(b) The Department shall have the authority and responsibility for providing case management and behavioral health rehabilitation services training classes on a regular basis but no less than six times during the year.

(c) Certified Behavioral Health Case ~~Manager~~Managers I ~~Training requirements – Meet the requirements for successful completion of the web-based competency exam and complete fourteen (14) hours of case management training as specified by the department.~~(CM I) must complete two days of case management training as specified by the Department.

(d) Certified Behavioral Health Case Manager II (CM II) Training requirements~~– Meet the requirements for successful completion of the web-based competency exam and complete seven (7) hours of case management training as specified by the department.~~:

(1) Complete the behavioral health case management web-based training as specified by the Department;

(2) Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Rehabilitation Association (USPRA) must complete the behavioral health rehabilitation web-based training as specified by the Department;

(2) Complete one day of face-to-face behavioral health case management training; and

(3) Non-CPRP candidates must complete two days of face-to-face behavioral health rehabilitation training.

~~(e) Certified Behavioral Health Case Manager III Training Requirements – Meet the requirements for successful completion of the web-based competency exam.~~

(~~f~~e) Case management certification training must be completed within six (6) months of ~~passing the exam~~the date of application. Once the six (6) month period has ended, an applicant that has not completed the training must wait a period of sixty (60) days before reapplying, and shall submit a new application.

(~~g~~f) ~~Enrollment to the certification training is not permitted without the successful completion of~~Approval to take the web-based competency exam is not permitted without completion of all training requirements.

**450:50-5-4. Continuing education requirements**

(a) Certified Behavioral Health Case Managers must complete twelve (12) hours continuing education per year and submit documentation of the continuing education to ODMHSAS annually for consideration.

(b) Continuing education is acceptable when it provides information to enhance delivery of behavioral health case management and behavioral health rehabilitation services and;

(1) Meets the requirements for LPC, LMFT, LBP, LCSW, CADC, LADC, or CME continuing education; or

(2) Is ~~a~~an undergraduate or graduate course in a behavioral health related field and pertains to direct interaction with consumers (three hours of course work is equal to twelve (12) hours of CEUs).

(3) The ODMHSAS Director of Community Based Services or designee shall approve all in-house/agency trainings that are provided for the intent of submitting towards case management CEUs (unless they meet the requirement in 450:50-5-4(b)(2). Certified case managers shall not submit more than three (3) hours of these approved CEUs annually towards their required minimum.

(c) Certified Behavioral Health Case Managers must complete, as part of their required twelve (12) hours annually, three (3) hours of ethics training every year. Ethics training must meet the requirements for LPC, LMFT, LBP, LCSW, CADC, LADC or CME ethics training; and annually, three (3) hours of training related to Strengths-Based/Recovery Principles.

(d) Certified Behavioral Health Case Managers shall retain documents verifying attendance for all continuing education hours claimed for the reporting period. Documentation shall be submitted upon the request of the Department. Acceptable verification documents include:

(1) An official continuing education validation form furnished by the presenter; or

(2) A letter or certificate from the organization sponsoring the training verifying name of program, presenter, number of hours attended, participant's name, and approval by licensure board; or

(3) An official grade transcript verifying completion of the undergraduate or graduate course. Ethics or Strengths based curriculum training must be verified with a course syllabus or other information submitted with official transcript.

(e) Failure to complete the continuing education requirements and submit the required documentation by the renewal date renders the certification in suspension, and results in the loss of all rights and privileges of a Certified Behavioral

Health Case Manager. The Certified Behavioral Health Case Manager certification may be reinstated during a period of no longer than six (6) months following the suspension date. ~~If not reinstated the certification shall become null and void.~~ The Certified Behavioral Health Case Manager has the right to renew the certificate by payment of renewal fees ($15.00) and late renewal fees ($25.00) and documentation of obtaining twelve (12) hours of continuing education.

**450:50-5-5. Web-based competency ~~exam~~ exams**

(a) ~~CBHCM III applicants passing the web-based competency exam will become fully certified. Those applicants who meet criteria for CBHCM I or II will have six (6) months after passing the web-based competency exam to complete the case management certification training.~~Successful completion of web-based competency exams for behavioral health rehabilitation and behavioral health case management is required prior to certification as CM II. CPRP applicants and applicants to be a CM I need only successfully complete the web-based competency exam for behavioral health case management.

(b) The web-based competency exam shall not be administered until all application and training requirements are met and approval from ODMHSAS has been received.

(c) Applicants shall comply with the rules of the examination process as outlined by the contracted testing site.

(d) Applicants who fail to complete and pass the web-based competency exam within six (6) months of the date of application must reapply.

## SUBCHAPTER 7. RULES OF PROFESSIONAL CONDUCT

**450:50-7-1. Responsibility and scope of practice**

(a) Certified Behavioral Health Case Managers shall be dedicated to advancing the welfare of individuals, and children and their families. Certified Behavioral Health Case Managers shall not participate in, condone, or be associated with dishonesty, fraud, deceit or misrepresentation, and shall not exploit their relationships with the consumers for personal advantage, profit, satisfaction, or interest.

(b) Certified Behavioral Health Case Managers shall practice only within the boundaries of their competence based on their education, training, supervised experience, state and national accreditations and licenses.

(c) Certified Behavioral Health Case Managers shall only use the title if employed by the state or a private or nonprofit behavioral health services provider contracting with the state to provide behavioral health services.

(d) Certified Behavioral Health Case Managers may not practice any of the following professions or use the following titles unless also licensed or accredited by the appropriate authority: physician, psychologist, clinical social worker, professional counselor, marital and family therapist, behavioral practitioner or alcohol and drug counselor.

(e) Certified Behavioral Health Case Managers shall not directly or indirectly suggest that they are allowed to provide "therapy" or "counseling" services unless licensed or accredited by the appropriate authority to provide therapy and/or counseling services.

(~~e~~f) Certified Behavior Case Managers shall adhere to the following code of ethics that are set within the rules of this chapter and set forth by the Department.

(1) Certified Behavioral Health Case Managers shall be committed to respect the dignity and autonomy of all persons that is to include, but is not limited to professional relationships with clients (or former clients), supervisees, students, employees, or research participants in efforts to maintain the highest standards of their practice.

(2) Certified Behavioral Health Case Managers shall terminate service to clients, and professional relationships with them, when such service and relationships are no longer required or in which a conflict of interest arises.

(3) Certified Behavioral Health Case Managers shall be aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. They shall also eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices or influence.

(4) Certified Behavioral Health Case Managers shall be obligated to report witnessed, involved, or reported ethical violations without violation of any confidentiality rights that may be involved. Certified Behavioral Health Case Managers shall be obligated to follow steps of reporting professional misconduct as set forth by the Department and in this chapter.

(5) Certified Behavioral Health Case Managers shall give precedence to his or her professional responsibility over personal interests.

(~~f~~g) Certified Behavioral Health Case Managers shall not exploit their relationships with current or former clients, supervisees, students, employees, or others, sexually or otherwise, for personal advantage, profit, satisfaction, or interest.

(1) Certified Behavioral Health Case Managers shall be committed to each individual's rights of their own life choices and recovery journey by letting them direct their own healing process.

(2) Certified Behavioral Health Case Managers shall keep confidential all information entrusted except when to do so puts the consumer at grave risk. Case Managers will be obligated to explain the limits of confidentiality initially in the professional working relationship.

(3) If the demands of an affiliated organization for whom the Certified Behavioral Health Case Manager is working, is in conflict with these ethics, the issues must be clarified and resolved to allow adherence to the Rules of professional Conduct code set forth in this chapter.

(~~g~~h) Certified Behavioral Health Case Managers shall provide services with populations and in areas only within the boundaries of their competence, based on education, training,

supervised experience, consultation, study or professional experience.

(1) Certified Behavioral Health Case Managers that delegate or assign work to employees, supervisee, or assistants must take reasonable steps to see that such person performs the services competently.

(2) Certified Behavioral Health Case Managers are eligible to provide ~~certified behavioral health case management~~ services within the scope of their certifications that would not lead to conflict of interest, exploitation of relationship, loss of objectivity and based on education, training or experience.

(3) Certified Behavioral Health Case Managers shall provide clients at the beginning of service written, accurate and complete information regarding the extent and nature of the services available to them, to include fees and manner of payment.

(4) Certified Behavioral Health Case Managers shall not solicit the clients of one's agency for private practice or to change service locations.

(5) Certified Behavioral Health Case Managers shall not commit fraud and shall not represent that she or he performed services which they did not perform.

**450:50-7-3. Reimbursement for services rendered**

Certified Behavioral Health Case Managers shall practice ~~case management services~~within the scope of their individual certifications only if employed by the State or a private or nonprofit behavioral health services provider contracting with the state to provide behavioral health services. As an employee of a state or a private or nonprofit behavioral health provider reimbursement for services rendered will not be collected outside of the agency's system of service reimbursement.

*[OAR Docket #13-883; filed 5-22-13]*

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## TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
## CHAPTER 70. STANDARDS AND CRITERIA FOR OPIOD ~~SUBSTITUTION~~ TREATMENT PROGRAMS

*[OAR Docket #13-884]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Chapter 70. Standards and Criteria for Opioid ~~Substitution~~ Treatment Programs [AMENDED]
**AUTHORITY:**
Oklahoma Department of Mental Health and Substance Abuse Services Board; 43A O.S. §§ 3-601 et seq.
**DATES:**
**Comment period:**
February 2, 2013 through March 5, 2013
**Public hearing:**
March 8, 2013
**Adoption:**
March 22, 2013
**Submitted to Governor:**
March 22, 2013
**Submitted to House:**
March 22, 2013
**Submitted to Senate:**
March 22, 2013
**Gubernatorial approval:**
April 29, 2013
**Legislature approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 17, 2013
**Final adoption:**
May 17, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
In accordance with the Administrative Procedures Act the proposed rule revisions to Chapter 70 are part of the Department's regular review of Title 450. The proposed changes to rule are intended to clarify and simplify existing rules, improve processes and are intended to comply with recent federal rule changes.
**CONTACT PERSON:**
Gretchen Geis, Administrative Rules Liaison, Department of Mental Health and Substance Abuse Services, Post Office Box 53277, Oklahoma City, Oklahoma 73152-3277, (405) 522-2053.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### SUBCHAPTER 1. GENERAL PROVISIONS

**450:70-1-1. Purpose**

This chapter is to set forth rules regulating program requirements, activities, and services which are not specific to levels of care and sets forth the standards and criteria used in the certification of facilities and organizations providing medication assisted opioid ~~substitution~~ treatment programs. The rules regarding the certification process, including, but not limited to, the application process, fees, and administrative sanctions are found in OAC 450:1, Subchapters 5 and 9.

**450:70-1-2. Definitions**

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

**"Accreditation"** means the process of review and acceptance by a nationally recognized accreditation body.

**"Accreditation body"** means a body that has been approved by SAMHSA to accredit opioid treatment programs using opioid agonist or partial agonist treatment medications.

**"Administer"** The direct application of a prescription drug by ingestion or any other means to the body of a patient by a licensed practitioner, or the patient at the direction of, or in the presence of, a practitioner.

**"Administrative withdrawal"** means a patient's medically supervised withdrawal involving the gradual tapering of dose of medication over time, coinciding with the patient's usually involuntary discharge from medication assisted treatment. Administrative withdrawal typically results from non-payment of fees, violent or disruptive behavior, incarceration or other confinement.

**"Approved narcotic drug"** means a drug approved by the United States Food and Drug Administration for maintenance and/or detoxification of a person physiologically~~ addicted to~~ dependnt upon opioid drugs.

**"American Society of Addiction Medicine Patient Placement Criteria"** or **"ASAM PPC"** means the most recent clinical guide published by the American Society of Addiction Medicine to be used in matching patients to appropriate levels of care.

**"Biopsychsocial assessment"** means in-person interviews conducted by a ~~treatment professional~~ service provider designed to elicit historical and current information regarding the behavior and experiences of a patient, and are designed to provide sufficient information for problem formulation, intervention planning, case management needs, and formulation of appropriate substance ~~0~~abuse-related treatment and service planning.

**"Buprenorphine"** means a partial agonist, Schedule III narcotic approved for use in opioid ~~addiction~~ dependence treatment~~, marketed as Subutex or Suboxone when combined with naloxone~~.

**"CARF"** means the Commission on the Accreditation of Rehabilitation Facilities.

**"Central registry"** A document or database to which an ~~OSTP~~OTP shall report patient identifying information about individuals who are applying for or undergoing medically supervised withdrawal or maintenance treatment on an approved opioid agonist or partial agonist to a central record system approved by the Commissioner or designee.

**"Certification"** means the process by which ODMHSAS or SAMHSA determine that an ~~OSTP~~OTP is qualified to provide opioid treatment under applicable State and Federal standards.

~~**"Certified opioid substitution treatment program"** means an opioid substitution treatment program with all current, required state and federal, current, valid certifications.~~

**"Chain of custody"** means the process of protecting items so that movement, possession and location are secure and documented and there is no possibility for altering or otherwise tampering with the item.

**"Chronic pain disorder"** means an ongoing condition or disorder consisting of chronic anxiety, depression, anger and changed lifestyle, all with a variable but significant level of genuine neurologically based pain. The pain becomes the main focus of the patient's attention, and results in significant distress and dysfunction.

**"Clinical Opioid Withdrawal Scale"** or **"COWS"** means a well validated, standardized assessment instrument for evaluating the severity of a patient's withdrawal through the identification of objective and subjective symptoms and the severity of these symptoms.

**"Clinical supervision"** means an organized process by which knowledgeable and skilled supervisors systematically and routinely provide ongoing and in-depth review of direct service providers' performance.

**"COA"** means the Commission on Accreditation.

**"Comprehensive maintenance treatment"** is:

(A) Dispensing or administering an approved opioid agonist or partial agonist medication at stable dosage levels for a period in excess of 21 days to a patient for opioid~~ addiction~~ dependence, and

(B) Providing medical, clinical and educational services to the patient with opioid ~~addiction~~ dependence.

**"Continuing care plan"** means a written plan of recommendations and specific referrals for implementation of continuing care services, including medications, shall be prepared for each patient meeting the ASAM Patient Placement Criteria dimensional continued service criteria. Continuing care plans shall be developed with the knowledge and cooperation of the patient. This continuing care plan may be included in the discharge summary. The patient's response to the continuing care plan shall be noted in the plan, or a note shall be made that the patient was not available and why. In the event of the death of a patient, a summary statement including this information shall be documented in the record.

**"Co-occurring disorder"** or **"COD"** means any combination of mental health and substance ~~abuse~~use disorder symptoms or diagnoses as determined by the current Diagnostic and Statistical Manual of Mental Disorders that affect a patient.

~~**"Co-occurring disorder capability"** means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to patients with co-occurring disorders. Co-occurring disorder capable programs address co-occurring disorders diagnosis in policy and procedures, assessment, treatment planning, program content, and transition planning.~~

**"Courtesy Dosing"** means the act of dosing a methadone or buprenorphine patient from another clinic on a short term basis due to emergency or other extra ordinary circumstance.

**"Critical incident"** means an occurrence or set of events inconsistent with the routine operation of an approved treatment facility, or the routine care of a patient. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries (including automobile accidents) to the patient, patient family, staff and visitors; medication errors; neglect or abuse of a patient; fire; unauthorized disclosure of information; damage to or theft of property belonging to a patient or an approved treatment facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

~~**"CSAT"** means Center for Substance Abuse Treatment.~~

**"Cultural competency"** means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

**"DEA"** means Drug Enforcement Administration.

**"Discharge planning"** means the process, beginning at admission of determining a consumer's continued need for treatment services and developing a plan to address ongoing consumer recovery needs.

**"Diskette"** means a compressed wafer form of methadone intended to be dissolved in water for consumption. For the purposes of this chapter methadone diskettes will not be considered to be the same as tablet methadone. Diskettes shall be dissolved in liquid prior to being dispensed, or dissolved in liquid by the patient in full and clear view of ~~OSTP~~OTP staff before the patient may leave the clinic with the dose.

**"Dispense"** means preparing, packaging, compounding and labeling for delivery, a prescription drug in the course of professional practice to an ultimate user by the lawful order of a physician.

**"Diversion"** means the unauthorized or illegal transfer of an opioid agonist or partial agonist treatment medication.

**"Diversion control plan"** or **"DCP"** means documented procedures to reduce the possibility that controlled substances are used for any purpose other than legitimate use.

**"Drug dispensing area"** means the specified and secured location established by the ~~OSTP~~OTP for dispensing opioid agonist or partial agonist drugs to the patients. The area shall be secure, meet all appropriate standards and be the only location within the facility where drugs are dispensed.

~~**"Drug stocks"** means the inventory of drugs stored and secured by the clinic, available for use in opioid agonist treatment.~~

**"Drug test"** means the assessment of an individual to determine the presence or absence of illicit or non-prescribed drugs or alcohol or to confirm maintenance levels of treatment medication(s), by a methodology approved by the ~~OSTP~~OTP medical director based on informed medical judgment and conforming to State and Federal law. This may include blood testing, oral-fluid and urine testing.

~~**"DSM"** means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.~~

**"Exception request process"** means a process recording the justification of the need to make a change in treatment protocol for an opioid patient and submitted to SAMHSA using form SMA-168.

~~**"Facility"** means any program authority, hospital, school, building, house or retreat, authorized by law to have the care, treatment or custody of the mentally ill or drug or alcohol dependent persons including, but not limited to, public or private hospitals, community mental health centers, clinics, satellites, institutions, organizations or agencies provided that the facility shall not mean a child guidance center operated by the State Department of Health.~~

**"FDA"** Federal Food and Drug Administration.

**"Federal opioid treatment standards"** means the established standards of SAMHSA, CSAT and the DEA that are used to determine whether an ~~OSTP~~OTP is qualified to engage in medication assisted opioid treatment.

**"HIPAA"** means ~~Healthcare~~Health Insurance Portability and Accountability Act

**"Holiday"** means those days recognized by the State of Oklahoma as holidays.

~~**"ICIS"** means Integrated Client Information Services.~~

**"Individualized ~~treatment~~ service planning"** means the ongoing process by which a clinician and the patient identify and rank problems, establish agreed upon goals, and decide on the treatment process and resources to be utilized.

**"Interim maintenance treatment"** means maintenance treatment provided in conjunction with appropriate medical services while a patient is awaiting transfer to a program that provides comprehensive maintenance treatment.

**"JC" or "TJC"** means the Joint Commission.

**"Liquid methadone"** means a liquid concentrate of methadone meant to be mixed with water for ingestion.

**"Lock box"** means a container with a combination lock or key lock entry system for securing take home medications. The box must have the ability to lock and should be secure enough to thwart access by children.

**"Long-term care facilities"** means a facility or institution that is licensed, certified or otherwise qualified as a nursing home or long term care facility by the state in which methadone or buprenorphine treatment services are rendered. This term includes skilled, intermediate, and custodial care facilities which operate within the terms of licensure.

**"Long-term detoxification treatment"** means detoxification treatment for a period of more than 30 days but less than 180 days.

~~**"Medical and rehabilitative services"** means services such as medical evaluations, counseling, and rehabilitative and other social programs (e.g., vocational and educational guidance, employment placement), intended to help patients in an OSTP to become and/or remain productive members of society.~~

**"Medical director"** means a physician, licensed to practice medicine in Oklahoma, who assumes responsibility for the administration of all medical services performed by an ~~OSTP~~OTP, either by performing them directly or by delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision, unless otherwise indicated in this chapter. This includes ensuring the program is in compliance with all federal, state, and local laws and regulations regarding the medical treatment of ~~addiction~~ dependence on~~to~~ an opioid drug.

**"Medical withdrawal"** means a condition created by administering an opioid agonist or partial agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state.

**"Medication unit"** means a satellite facility established as part of, but geographically separate from, an ~~OSTP~~OTP from which appropriately licensed~~ private~~ practitioners~~ or community pharmacists~~ dispense or administer an opioid agonist or partial agonist treatment medication or collect samples for drug testing or analysis. No medical or clinical interventions related to OTP treatment can be conducted at this site.

~~**"Methadone detoxification treatment"** means the process of dispensing or administering of an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects related to withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state.~~

**"Non-oral methadone"** means an injectable form of methadone not allowed for use by an ~~OSTP~~OTP.

**"Nurse practitioner"** means a registered nurse who is prepared through advanced education and clinical training, to provide a wide range of health care services.

**"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

**"Oklahoma Administrative Code"** or **"OAC"** means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1) (a) and maintained in the Office of Administrative Rules.

**"OBNDD"** means the Oklahoma Bureau of Narcotics and Dangerous Drug Control.

**"Oklahoma state-issued identification card"** means a photo identification card issued by the Oklahoma Department of Motor Vehicles for use in identification.

**"Opiate drug"** means any of a class of drugs also called narcotics derived from the opium poppy or containing opium and with analgesic or sedative effects that can form sustain or enhance addiction and physical dependency.

~~**"Opioid addiction"** means a cluster of cognitive, behavioral, and physiological symptoms in which an individual continues use of opioids despite significant opioid-induced problems. Opioid dependence is characterized by repeated self-administration resulting in opioid tolerance, withdrawal symptoms, and compulsive drug-taking. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal.~~

**"Opioid agonist"** means a drug that has an affinity for and stimulates physiologic activity at cell receptors in the central nervous system normally stimulated by opioids. Methadone is an opioid agonist.

**"Opioid agonist or partial agonist treatment medication"** means a prescription medication, such as methadone, buprenorphine or other substance scheduled as a narcotic under the Federal Controlled Substances Act (21 U.S.C. Section 811) that is approved by the U.S. Food and Drug Administration for use in the treatment of opiate addiction or dependence.

**"Opioid antagonist"** means a drug that binds to cell receptors in the central nervous system that normally are bound by opioid psychoactive substances and that blocks the activity of opioids at these receptors without producing the physiologic activity produced by opioid agonists. Naltrexone is an opioid antagonist.

**"Opioid dependence"** ~~see opioid addiction.~~ means a cluster of cognitive, behavioral, and physiological symptoms in which an individual continues use of opioids despite significant opioid-induced problems. Opioid dependence is characterized by repeated self-administration resulting in opioid tolerance, withdrawal symptoms, and compulsive drug-taking. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal.

**"Opioid drug"** means any of a class of drugs also called narcotics, having a ~~an addiction~~ dependence-forming or ~~addiction~~ dependence-sustaining liability similar to morphine. Originally a term for synthetic narcotics only, but for the purposes of this chapter and unless otherwise specified, currently used to describe both opium based and synthetic narcotics. These drugs have analgesic or sedative effects.

**"Opioid partial agonist"** means a drug that binds to, but incompletely activates, opiate receptors in the central nervous system, producing effects similar to those of an opioid agonist but, at increasing doses, does not produce as great an agonist effect as do increased doses of an agonist. Buprenorphine is a partial opioid agonist.

**"Opioid treatment"** means the dispensing of ~~an~~ opioid agonist or partial agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opioid ~~addiction~~ dependence. This term encompasses detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment or comprehensive maintenance treatment, interim maintenance treatment and treatment provided in medication units, long term care facilities or hospitals.

**"Opioid ~~Substitution~~ Treatment Program ~~(OSTP)~~(OTP)"** An organization which has been certified by ODMHSAS to provide opioid treatment whose certification has not been suspended, revoked, or surrendered to the department, referred to in statute as an Opioid Substitution Treatment Program.

**"Pain management"** means the successful management of chronic pain or a chronic pain disorder.

~~**"Paraprofessional"** means a person who does not have an academic degree related to the scope of treatment or support services being provided but performs prescribed functions under the general supervision of that discipline.~~

~~**"Patient based planning"** means an organized and systematic method of basing treatment and services on the needs of current and prospective patients.~~

**"Patient record"** or **"medical record"** means the collection of written information about a patient's evaluation or treatment that includes the intake data, evaluation, ~~treatment or~~ service plan, description of ~~treatment or~~ services provided, medications as prescribed, continuing care plan, and discharge information on an individual patient.

**"Parenteral"** means injected, infused or implanted, used to describe drug administration other than oral or anal.

**"Peak test"** see Peak and Trough.

**"Peak and trough test"** means a therapeutic monitoring of serum methadone levels to determine the most appropriate dosing strategy for the individual patient, requiring at least two blood samples be drawn. The initial sample taken immediately prior to the daily dose and twenty four hours after the previous day's dose allowing the lowest level or "trough" to be identified. The second sample taken four hours after dosing allows the highest level or "peak" to be identified.

**"Physician assistant"** means a licensed or certified mid-level medical practitioner who works under the supervision of a licensed physician (MD) or osteopathic physician (DO).

**"Program physician"** A licensed physician who provides medical treatment and counsel to the patients of an ~~OSTP~~OTP while under the supervision of the medical director.

**"Program sponsor"** A person named in the application for an ~~OSTP~~OTP permit who is responsible for the operation of the ~~OSTP~~OTP and who assumes responsibility for all its employees, including any practitioners, staff, or other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director.

**"SAMHSA"** means the Substance Abuse and Mental Health Services Administration.

**"Sentinel event"** means a type of critical incident that is an unexpected occurrence involving the death or serious injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for an immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events (including medication overdoses by patients and associates of patients) resulting in serious injury or death.

**"Service Provider"** means a person who is allowed to provide services for those with substance use disorders within the regulation and scope of their certification level or license.

**"Short-term detoxification treatment"** means detoxification treatment for a period not in excess of 30 days.

~~**"State Methadone Authority" or "SMA"** is the agency designated by the Governor or other appropriate official designated by the Governor to exercise the responsibility and authority within the State or Territory for governing the treatment of opioid addiction with an opioid drug. For Oklahoma it is the The Oklahoma Department of Mental Health and Substance Abuse Services.~~

**"State Opioid Treatment Authority" or "SOTA"** is the agency designated by the Governor or other appropriate official designated by the Governor to exercise the responsibility and authority within the State or Territory for governing the treatment of opioid dependence with an opioid drug. For Oklahoma it is the Oklahoma Department of Mental Health and Substance Abuse Services.

**"STD"** means sexually transmitted disease.

**"Street outreach"** means methods of direct intervention/prevention with high risk populations for HIV, HCV, tuberculosis and other infectious and communicable diseases.

**"Tablet methadone"** means methadone in a tablet form intended to be taken orally. For the purposes of this chapter diskettes will not be considered to be tablet methadone. Tablet methadone is not allowed for use by an ~~OSTP~~OTP.

**"Take-home privilege or take home medication"** means one or more doses of an opioid agonist or partial agonist treatment medication dispensed to a patient for use off the premises.

**"Therapeutic hour(s)"** means the amount of time in which the patient was engaged with a ~~treatment professional~~ service provider in identifying, addressing, and/or resolving those issues that have been identified in that patients treatment plan. ~~This time frame can be no less than thirty (30) minutes.~~

**"Transient consumer"** means a methadone or buprenorphine patient from another geographic location requiring "courtesy dosing".

~~**"Treatment professional"** means any person allowed to provide alcohol and drug counseling, or is under supervision pursuant to the Licensed Alcohol and Drug Counselors Act, or otherwise exempt by law.~~

**"Trough test"** see Peak and Trough.

**"Urine analysis~~or~~(UA)"** means a urine sample taken to determine if metabolites are present indicating the use of drugs.

**"Withdrawal treatment"** means either administrative withdrawal, or medical titration and withdrawal from any drug or medication until the patient has achieved a drug free state.

### 450:70-1-4. Applicability

(a) This chapter is applicable to all certified substance ~~abuse~~ use disorder treatment facilities and organizations providing medication assisted opioid ~~substitution~~ treatment, opioid detoxification or opioid maintenance using methadone or buprenorphine including but not limited to counseling, rehabilitation services and substance abuse treatment services including methadone and buprenorphine maintenance treatment, short term detoxification treatment, long term detoxification treatment or interim maintenance treatment which are statutorily required to be certified and approved by the ODMHSAS, the Alcohol and Drug Abuse Prevention, Training and Rehabilitation Authority [43A O.S. § 3-601,(c)].

(b) Any conviction for a violation of any rule in this Part which has been promulgated pursuant to the provisions of 43A O.S. § 3-601 shall be a felony [43A O.S. § 3-601(B)].

### 450:70-1-5. Compliance review of standards and criteria [REVOKED]

~~The standards and criteria in this chapter shall be annually reviewed by the ODMHSAS. Compliance with these standards and criteria may be determined by a review of the following:~~

~~(1) Progress notes,~~

~~(2) Policy and Procedures,~~

~~(3) Review of all facility records,~~

~~(4) Interviews with staff and patients, and~~

~~(5) Investigations, site visits, treatment protocols, patient records, clinical service manuals and certification reviews.~~

## SUBCHAPTER 2. FACILITY INFRASTRUCTURE REQUIRMENTS

**450:70-2-1. Physical facility environment and safety**

(a) All facilities providing medication assisted opioid ~~substitution~~ treatment service shall have written policies and procedures intended to ensure the safety and protection of all persons within the facility's physical environment (property and buildings, leased or owned).

(b) These policies and procedures shall include, but are not limited to:

(1) Meeting all fire and safety regulations, code and statutory requirements of federal, state, ~~tribal,~~ or local government. ~~All OSTPs shall have an annual fire and safety inspection from the State Fire Marshal, tribal, or local authorities; and shall maintain a copy of said inspection and attendant correspondence regarding any deficiency.~~

(2) All OTPs shall have an annual fire and safety inspection approving continued occupancy from the State Fire Marshal, or local authorities; and shall maintain a copy of said inspection and attendant correspondence regarding the clearing of any deficiency.

(~~2~~3) An emergency preparedness plan to provide effective utilization of resources to best meet the physical needs of patients, visitors, and staff during any disaster (including, but not limited to; fire, flood, tornado, explosion, prolonged loss of heat, light, water, and/or air conditioning).

(A) This plan shall include procedures facilitating the transfer of patients in the event the ~~OSTP~~OTP is unable to open.

(B) This plan shall be evaluated annually, and revised as needed.

(~~3~~4) A designated Safety Officer.

(~~4~~5) Staff training and orientation regarding the location and use of all fire extinguishers and first aid supplies and equipment and an emergency preparedness plan.

(~~5~~6) Emergency evacuation routes and shelter areas shall be prominently posted in all areas.

~~(6) Fire alarm systems shall have visual signals suitable for the deaf and hearing impaired.~~

(7) There shall be emergency power to supply lighting to pre-selected areas of the facility.

(8) The maintenance of facility grounds to provide a safe environment for consumers (specific to age group[s] served), staff and visitors.

(9) Storage of dangerous substances (toxic or flammable substances) in locked, safe areas or cabinets.

(10) A written plan for the protection and preservation of consumer records in the event of a disaster.

(c) Compliance with 450:70-2-1 may be determined by a review of:

(1) Facility policy and procedures,

(2) Fire and safety inspection reports and correspondence,

(3) Disaster plans,

(4) Any other supporting facility documentation, and

(5) Interviews with staff and consumers.

**450:70-2-2. Hygiene and sanitation**

(a) ~~OSTPs~~OTPs shall provide:

(1) Lavatories and toilet facilities in a minimum ratio of one per twenty persons on site.

(2) Sewerage discharge into a municipal sewerage system or collected, treated and disposed of in an independent sewerage system.

(3) Solid waste disposal through public systems or in a manner approved by the local agency having jurisdiction and the Oklahoma State Department of Health or Department of Environmental Quality, as necessary.

(4) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the Oklahoma Department of Health or Department of Environmental Quality, as indicated by the building permit.

(5) The facility shall have proof of regular inspections and treatment by a licensed pest control operator.

(6) House-keeping services so that a hygienic environment is maintained in the facility.

(b) Compliance with 450:70-2-2 may be determined by:

(1) A review of utility/garbage bills,

(2) Water testing results,

(3) Pest inspections and

(4) Other related documents.

## SUBCHAPTER 3. FACILITY RECORD SYSTEM

## PART 1. RECORD SYSTEM

**450:70-3-1. Purpose [REVOKED]**

~~All OSTPs shall document and maintain records as described in Subchapter 3.~~

**450:70-3-2. Patient record system**

(a) Each ~~OSTP~~OTP shall maintain an organized system for the content, confidentiality, storage retention and disposition of patient records.

(b) The ~~OSTP~~OTP shall have written policies and procedures concerning patient records which define required documentation within the patient record.

(c) Patient records shall be maintained in a locked and secure manner.

(d) The ~~OSTP~~OTP shall maintain identification and filing systems which enable prompt record location and accessibility by ~~treatment professionals~~ service providers.

(e) Patient records shall be maintained in the facility where the individual is being treated or served. In the case of temporary office space or satellites, records may be maintained in the main (permanent) office and transported in secured lock boxes to and from temporary offices or satellites, when necessary. Patient records may be permanently maintained at the ~~OSTP's~~OTPs administrative offices; however, a working copy of the patient record for the purposes of documentation

and review of services provided must be maintained at the site in which the patient is receiving treatment.

(f) The ~~OSTP~~OTP shall have policies which govern the storage, retention, and disposition of patient records, including electronic records. These policies shall be compatible with protection of patient's rights against confidential information disclosure at a later date, and compliant with applicable state and federal law.

(g) Compliance with 450:70-3-2 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records,

(3) Performance improvement guidelines,

(4) Interviews with staff, and

(5) Other facility documentation.

**450:70-3-3. Patient records, basic requirement**

(a) Patient records shall be developed and maintained to ensure that all appropriate individuals have access to relevant clinical and other information regarding the patient. The patient record shall communicate information in a manner that is organized, clear, complete, current and legible. All patient records shall contain the following:

(1) Entries in patient records shall be legible, signed with first name or initial, last name, and dated by the person making the entry;

(2) The patient shall be identified by name~~ and unique identifier~~ on each sheet in the patient record and on each screen of the electronic record.~~, readily identifiable, on both sides of each page if both sides are used;~~

(3) A signed consent for treatment shall be obtained and placed in the record before any person can be admitted into treatment at an ~~OSTP~~OTP;

(4) A signed consent for follow-up shall be obtained and placed in the record before any contact after discharge can be made;

(5) An intake and admission assessment;

(6) A biopsychsocial assessment;

(7) Case management needs assessment;

(8) ~~Treatment~~ Service planning;

(9) Documentation of progress notes;

(10) A discharge biopsychsocial assessment;

(11) A continuing care plan;

(12) Consultation reports;

(13) Psychological or psychometric testing;

(14) Records and reports from other entities;

(15) Medication records;

(16) A discharge summary; and

(17) Referral and transfer~~;~~.

~~(18) Consultation reports;~~

~~(19) Psychological or psychometric testing;~~

~~(20) Records and reports from other entities;~~

~~(21) Medication records; and~~

~~(22) Referrals and transfers.~~

~~(A) The OSTP shall refer patients to other resources when the individual has treatment or service needs the facility does not provide.~~

~~(B) The OSTP shall maintain a directory of currently available resources, which shall, at a minimum, contain the "ODMHSAS Yellow Pages."~~

~~(C) The transferring program must supply patient medical records necessary in response to a written request and a valid consent form within fifteen (15) days of receipt and in compliance with all applicable state and federal law.~~

~~(i) The program shall furnish copies of medical records requested, or a summary or narrative of the records, including records received from a physician or other health care provider involved in the care or treatment of the patient, pursuant to a written consent for release of the information, except if the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient, and the program may delete confidential information about another patient or family member of the patient who has not consented to the release.~~

~~(ii) The information shall be furnished by the program within fifteen (15) days after the date of receipt of the request.~~

~~(iii) If the program denies the request, in whole or in part, the program shall furnish the patient a written statement, signed and dated, stating the reason for the denial. A copy of the statement denying the request shall be placed in the patient's record.~~

(b) Compliance with 450:70-3-3 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records,

(3) Performance improvement guidelines,

(4) Interviews with staff, and

(5) Other facility documentation.

**450:70-3-3.1. Patient transfer**

(a) The OTP shall refer patients to other resources when the individual has treatment or service needs the facility does not provide.

(1) The OTP shall maintain a directory of currently available local resources.

(2) The transferring program must supply patient medical records necessary in response to a written request and a valid consent form within fifteen (15) days of receipt and in compliance with all applicable state and federal law.

(A) The program shall furnish copies of medical records requested, or a summary or narrative of the records, including records received from a physician or other health care provider involved in the care or treatment of the patient, pursuant to a written consent for release of the information, except if the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient, and the program may delete confidential information about another patient or family member of the patient who has not consented to the release.

(B) The information shall be furnished by the program within fifteen (15) days after the date of receipt of the request.

(C) If the program denies the request, in whole or in part, the program shall furnish the patient a written statement, signed and dated, stating the reason for the denial. A copy of the statement denying the request shall be placed in the patient's record.

(b) Compliance with 450:70-3-3.1 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records,

(3) Performance improvement guidelines,

(4) Interviews with staff, and

(5) Other facility documentation.

**450:70-3-4. Confidentiality of drug or alcohol abuse or mental health treatment information**

Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20.1 and OAC ~~450:15-30-60~~450:15-60. ~~All facilities shall have policy and procedures protecting the confidential and privileged nature of mental health and substance abuse treatment information in compliance with state and federal law and which contain at a minimum:~~

~~(1) An acknowledgment that all mental health and substance abuse treatment information, whether recorded or not, and all communications between a physician or psychotherapist and a consumer are both privileged and confidential and will not be released without the written consent of the consumer or the consumer's legally authorized representative;~~

~~(2) An acknowledgment that the identity of a consumer who has received or is receiving mental health or substance abuse treatment services is both confidential and privileged and will not be released without the written consent of the consumer or the consumer's legally authorized representative;~~

~~(3) A procedure to limit access to mental health and substance abuse treatment information to only those persons or agencies actively engaged in the treatment of the patient and to the minimum amount of information necessary to carry out the purpose for the release;~~

~~(4) A procedure by which a consumer, or the consumer's legally authorized representative, may access the consumer's mental health and substance abuse treatment information;~~

~~(5) An acknowledgement that certain state and federal law exceptions to disclosure of mental health and drug or alcohol abuse treatment information without the written consent of the consumer or the consumer's legally authorized representative exist and the facility will release information as required by those laws and~~

~~(6) A procedure by which to notify a consumer of his or her right to confidentiality.~~

~~(7) Compliance with 450:18-7-3.1 shall be determined by a review of facility policy and procedures; facility forms; consumer record reviews; interviews with staff and consumers; and any other supporting facility documentation.~~

## PART 3. INTAKE AND ADMISSION ASSESSMENT

**450:70-3-5. Intake assessment and record content - Medical**

(a) All ~~OSTPs~~OTPs shall assess each individual for appropriateness for admission, ensuring the individual is placed in the least restrictive level of care.

(b) Each ~~OSTP~~OTP shall ensure that patients are admitted to ~~short or long term detoxification~~ treatment by a program physician, who determines that such treatment is appropriate for the specific patient by applying current and established DSM diagnostic and ASAM placement criteria.

(c) The ~~OSTP~~OTP shall have written policy and procedure stating the program shall require each patient to undergo a complete, fully documented history and physical examination by the medical director, a program physician or physician with a valid Oklahoma license before admission to the medication assisted opioid treatment program. For the purposes of this chapter, a Physician Assistant or Nurse Practitioner, with appropriate Oklahoma license/certification and working under the direction and supervision of the OTP medical director may perform services allowed by Oklahoma certification or licensure such as those listed here, unless otherwise specified. A full medical examination, including the results of serology and other tests, must be completed within fourteen (14) days following admission.

~~(d) Patients who have had a complete history and physical including laboratory tests within the past three months may be admitted to the OSTP without a new medical examination and laboratory tests, unless the program physician requests it. The admitting program shall obtain copies of these results within fifteen (15) days of admission. If records are not obtained within fifteen (15) days, the program shall conduct a complete history and physical.~~

~~(e) The OSTP shall have written policy and procedure stating any drugs approved for use in treating opioid dependency when used by an OSTP for persons with a history of addiction, or physiologic dependence, shall only be used in treating persons with a history of addiction of two (2) years or more as verified by the medical director or a program physician through medical examination; or persons with a one (1) year history of addiction and written documentation from an agency at which another type of addiction treatment was attempted or accomplished. Such documentation shall be received prior to admission to the program and/or induction of any drug uses as a part of an opioid substitution treatment regimen.~~

~~(f) Any patient seeking admission while under the influence, or undergoing withdrawal of alcohol or drugs shall be assessed prior to admission for medical needs. The written criteria to be used for medical needs assessment shall be approved by the OSTP Medical Director and meet state and federal requirements regarding standards of care.~~

~~(g) Using a standardized and accepted instrument (such as the COWS Scale) no patient shall be admitted to opioid substitution treatment unless symptoms of opioid dependency listed below are present with at least two symptoms coming from numbers one (1) through seven (7);~~

~~(1) Elevated resting pulse rate;~~

~~(2) Increased sweating;~~

~~(3) Tremors;~~

~~(4) Variation in pupil size;~~

~~(5) Increased yawning;~~

~~(6) Runny nose and/or tearing;~~

~~(7) Presence of "gooseflesh";~~

~~(8) Increased restlessness;~~

~~(9) Bone and/or joint pain;~~

~~(10) Increased anxiety or irritability; or~~

~~(11) Gastrointestinal distress.~~

~~(h) The OSTP shall have written policy and procedure stating the patient record shall contain adequate documentation of any prescription drug, including methadone, that a patient may be taking, including the name of the drug, the prescription number, the dose, the reason for prescribing, the name of the prescribing doctor, the pharmacy's name and telephone number, the date it was prescribed, and the length of time the patient is to be taking the drug. A release of information to the prescribing physician either by mail, facsimile or other acceptable electronic means allowing the medical director to coordinate treatment and discuss medications.~~

~~(i) The OSTP shall have written policy and procedure stating that if clinically appropriate, the program physician may waive the requirement of a one (1) year history of opioid addiction for:~~

~~(1) A patient within six (6) months of release from a correctional institution;~~

~~(2) A patient with a pregnancy verified by the program physician; or~~

~~(3) A patient having previously received opioid substitution treatment and within two (2) years of discharge from an OSTP.~~

~~(j) The OSTP shall have written policy and procedure stating that patients with two (2) or more unsuccessful detoxification episodes within a twelve (12) month period must be assessed by the medical director or a program physician for identification of need for other forms of treatment. An OSTP shall not admit a patient for more than two (2) detoxification treatment episodes in one (1) year.~~

~~(k) The OSTP shall have written policy and procedure stating any person under the age of eighteen (18) years of age requesting maintenance treatment shall have written documentation of two (2) unsuccessful attempts at short-term detoxification or drug-free treatment within a twelve (12) month period to be considered eligible for maintenance treatment.~~

~~(1) Such documentation shall be received prior to admission to the program or the induction of any drug used as a part of an opioid substitution treatment regimen.~~

~~(2) No person under eighteen (18) years of age may be admitted to maintenance treatment unless a parent, legal guardian or otherwise legally responsible adult designated by the relevant state authority consents in writing to such treatment.~~

~~(l) The OSTP shall have written policy and procedure outlining the requirement for the reporting of persons receiving opioid substitution treatment to the ODMHSAS. This report to the Central Registry shall be made in a form requested by the Commissioner or designee and within twenty-four (24) hours of admission, change of medical status or discharge of any patient.~~

~~(m) The OSTP shall have written policy and procedure stating the admission requirements for opioid substitution treatment programs.~~

~~(n) All applicants for opioid substitution treatment shall sign a written consent for opioid treatment in the primary language of the applicant.~~

~~(o) The patient intake information shall contain, but not be limited to, the following:~~

~~(1) Date of initial contact requesting services;~~

~~(2) Identification information, including Patient's name, home address, and telephone number;~~

~~(3) Referral source;~~

~~(4) Mental status examination and findings;~~

~~(5) History and physical information;~~

~~(6) Family to be notified in case of emergency; and~~

~~(7) If the facility reports on ICIS, the ICIS intake data core content.~~

~~(p) All OSTPs shall document and assess all patients for appropriateness of admission taking into account the patient's needs as identified by, but not limited to:~~

~~(1) Acute intoxication and withdrawal potential;~~

~~(2) Biomedical conditions and complications;~~

~~(3) Emotional and behavioral conditions and complications;~~

~~(4) Readiness to change;~~

~~(5) Relapse potential; and~~

~~(6) Recovery environment.~~

~~(q) The OSTP shall have a written policy and procedure that shall be made available to all patients, outlining rehabilitation services. Minimum services include:~~

~~(1) Individual counseling until the patient is fully stabilized and as indicated in this chapter;~~

~~(2) Group and family counseling for spouses, parents, or significant others and as indicated in this chapter;~~

~~(3) Vocational or educational counseling and referral and as indicated in this chapter; and~~

~~(4) Referral for additional services as outlined by the individualized treatment plan.~~

~~(r) The OSTP shall have written policy and procedure requiring the patient to be informed of all services that are available through the agency; and of all policies and procedures that may impact the patient's treatment.~~

~~(s) The OSTP shall have written policy and procedure requiring the patient be informed of the following upon admission:~~

~~(1) The progression of opioid addiction and the patient's assessed stage of opioid addiction;~~

~~(2) The goal and benefits of opioid treatment;~~

~~(3) The signs and symptoms of overdose and when to seek emergency assistance;~~

~~(4) The characteristics of opioid agonist treatment medication, including common side effects and potential interaction effects with non opioid agonist treatment medications and/or illicit drugs;~~

~~(5) The requirement for staff members to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult;~~

~~(6) The requirement for staff members to comply with the confidentiality requirements of 42 CFR Part 2 and 45 CFR parts 160 and 164;~~

~~(7) Drug screening and urinalysis procedures;~~

~~(8) Take home medication requirements;~~

~~(9) Testing and treatment available for HIV, HCV, tuberculosis and other communicable diseases;~~

~~(10) The process for a patient to file a grievance with the agency for any reason, including involuntary discharge, and to have the client's grievance handled in a fair and timely manner; and~~

~~(11) The process for a patient to file a grievance with the ODMHSAS Patient Advocate office agency for any reason, including involuntary discharge.~~

~~(t) The OSTP shall have written policy and procedure requiring the OSTP to see that an individual who requires administration of opioid agonist treatment medication only for relief of chronic pain is:~~

~~(1) Identified during the physical examination or assessment;~~

~~(2) Not admitted for opioid agonist medication treatment; and~~

~~(3) Referred to appropriate medical services.~~

~~(u) The OSTP shall have written policy and procedure requiring treatment by a multi disciplinary team of medical practitioners; including specialists in addiction medicine and pain management, for physically dependent or addicted patients with a chronic pain disorder. The OSTP shall coordinate with the physician treating the patient for pain.~~

~~(v) The OSTP shall have written policy and procedure requiring the facility to ensure that, if, during the assessment or physical examination, a determination is made that a patient may have a mental disorder, the patient is referred for assessment and treatment of the mental disorder. The OSTP will have written procedures including all required consents, for communication and collaboration with the patient's behavioral health professional to monitor and evaluate interactions between the client's opioid agonist treatment medication and any medications used to treat the patient's mental disorder.~~

~~(w) The OSTP shall have written policy and procedure requiring the OSTP to ensure that, if, during the assessment or physical examination, a determination is made that a patient may have a medical condition requiring intervention, the patient is referred for assessment and treatment of the medical condition. The OSTP will have written procedures including all required consents, for communication and collaboration with the patient's health professional to monitor and evaluate interactions between the patient's opioid agonist treatment medication and medications used to treat the patient's medical condition.~~

~~(x) The OSTP shall have written policy and procedure allowing the medical director to refuse the admission and/or opioid treatment to any patient if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.~~

~~(y) The OSTP shall have written policy and procedure requiring the patient must present a valid form of photo identification which can include; valid driver's license from the State of residence, United States passport, military identification card, or state issued identification card containing a photograph of the patient from the State of residence, Tribal ID card with photograph, or other identification approved by the State Methadone Authority. Photocopies shall be obtained upon admission and the copy must be maintained in the patient's record. The program shall document in the patient's file attempts to induce the patient to obtain state identification.~~

~~(z) OSTPs shall develop and maintain written policies and procedures that are adequate to ensure that the following dosage form and initial dosing requirements are met:~~

~~(1) Methadone shall be administered or dispensed only in oral and liquid form and shall be formulated in such a way as to reduce its potential for parenteral abuse. Diskettes shall be dissolved in liquid prior to being dispensed, or dissolved in liquid by the patient in full and clear view of OSTP staff.~~

~~(2) For each new patient enrolled in a program, the initial dose of methadone shall not exceed thirty (30) milligrams and the total dose for the first day shall not exceed forty (40) milligrams, unless the program physician documents in the patient's record that forty (40) milligrams did not suppress opiate abstinence symptoms. Any increase above forty (40) milligrams shall be based on the physician's medical judgment and documented in the chart.~~

~~(aa) Facilities must ensure that a patient's refusal of a particular service does not preclude the patient from accessing other needed mental health or substance abuse services. Should the treatment professional determine the patient's needs cannot be met within the facility, clinical documentation of assessments and referrals for the patient shall contain, at a minimum:~~

~~(1) Date of initial contact requesting services;~~

~~(2) Identification information, including Patient's name, home address and telephone number;~~

~~(3) Referral source;~~

~~(4) Mental status examination and results;~~

~~(5) History and physical;~~

~~(6) Family to be notified in case of emergency;~~

~~(7) If the facility reports on ICIS, the ICIS intake data core content;~~

~~(8) A continuing care plan;~~

~~(9) What agency was contacted; and~~

~~(10) Where and why the individual was referred.~~

(d) Compliance with 450:70-3-5 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.1. Intake assessment and record content - History**

(a) Patients who have had a complete history and physical including laboratory tests within the past three months may be admitted to the OTP without a new medical examination and laboratory tests, unless the program physician requests it. The admitting program shall obtain copies of these results within fifteen (15) days of admission. If records are not obtained within fifteen (15) days, the program shall conduct a complete history and physical.

(b) The OTP shall have written policy and procedure stating any drugs approved for use in treating opioid dependency when used by an OTP for persons with a history of physiologic dependence, shall only be used in treating persons with a history of symptoms of opioid dependency as stated in Title 43A, Section 3-601 A. 1. and as verified by the medical director or a program physician through medical examination; or persons with a history of dependence as stated in Title 43A, Section 3-601 A. 1. and written documentation from an agency at which another type of substance use disorder treatment was attempted or accomplished. Such documentation shall be received prior to admission to the program and/or induction of any drug uses as a part of an opioid treatment regimen. When buprenorphine is used to provide medication assisted treatment in this setting, a one year history of dependence shall be required.

(c) The OTP shall have written policy and procedure stating that if clinically appropriate, the program physician may waive the requirement as stated in Title 43A, Section 3-601 A. 1. for:

(1) A patient within six (6) months of release from a correctional institution;

(2) A patient with a pregnancy verified by the program physician; or

(3) A patient having previously received opioid substitution treatment and within two (2) years of discharge from an OTP.

(d) Compliance with 450:70-3-5.1 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.2. Intake assessment and record content - Symptoms**

(a) Any patient seeking admission while under the influence, or undergoing withdrawal of alcohol or drugs shall be assessed prior to admission for medical needs. The written criteria to be used for medical needs assessment shall be approved by the OTP medical director and meet state and federal requirements regarding standards of care.

(b) Using a standardized and accepted instrument (such as the COWS Scale) no patient shall be admitted to medication assisted opioid treatment unless symptoms of opioid dependency listed below are present with at least two symptoms coming from numbers one (1) through seven (7);

(1) Elevated resting pulse rate;

(2) Increased sweating;

(3) Tremors;

(4) Variation in pupil size;

(5) Increased yawning;

(6) Runny nose and/or tearing;

(7) Presence of "gooseflesh";

(8) Increased restlessness;

(9) Bone and/or joint pain;

(10) Increased anxiety or irritability; or

(11) Gastrointestinal distress.

(c) Compliance with 450:70-3-5.2 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.3. Intake assessment and record content - Dispensed and prescribed pharmaceuticals**

(a) The OTP shall have written policy and procedure stating the patient record shall contain adequate documentation of any prescription drug, including methadone or buprenorphine, that a patient may be taking, including the name of the drug, the prescription number, the dose, the reason for prescribing, the name of the prescribing doctor, the pharmacy's name and telephone number, the date it was prescribed, and the length of time the patient is to be taking the drug. A release of information to the prescribing physician either by mail, facsimile or other acceptable electronic means allowing the medical director to coordinate treatment and discuss medications.

(b) Compliance with 450:70-3-5.3 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.4. Intake assessment and record content - Level of care**

(a) The OTP shall have written policy and procedure stating that patients with two (2) or more unsuccessful detoxification episodes within a twelve (12) month period must be assessed by the medical director or a program physician for identification of need for other forms of treatment. An OTP shall not admit a patient for more than two (2) detoxification treatment episodes in one (1) year.

(b) Compliance with these standards and criteria may be determined by a review of the following:

(1) Policy and Procedures,

(2) Review of all facility records, and

(3) Investigations, site visits, treatment protocols, patient records, clinical service manuals and certification reviews.

**450:70-3-5.5. Intake assessment and record content - Care of minors**

(a) The OTP shall have written policy and procedure stating any person under the age of eighteen (18) years of age requesting maintenance treatment shall have written documentation of an unsuccessful attempt at short-term detoxification

or drug-free treatment within a twelve (12) month period to be considered eligible for maintenance treatment.

(b) Such documentation shall be received prior to admission to the program or the induction of any drug used as a part of an opioid treatment program regimen.

(c) No person under eighteen (18) years of age may be admitted to maintenance treatment unless a parent, legal guardian or otherwise legally responsible adult designated by the relevant state authority consents in writing to such treatment.

(d) Compliance with 450:70-3-5.5 may be determined by:

(1) A review of policies and procedures,

(2) treatment records, and

(3) Other facility documentation.

**450:70-3-5.6. Intake assessment and record content - Central registry**

(a) The OTP shall have written policy and procedure outlining the requirement for the reporting of persons receiving medication assisted opioid treatment to the ODMHSAS. This report to the Central Registry shall be made in a form requested by the Commissioner or designee and within twenty-four (24) hours of admission, change of medical status or discharge of any patient.

(b) Compliance with 450:70-3-5.6 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.7. Intake assessment and record content - Intake content**

(a) The OTP shall have written policy and procedure stating the admission requirements for opioid treatment programs.

(b) All applicants for medication assisted opioid treatment shall sign a written consent for opioid treatment in the primary language of the applicant.

(c) The patient intake information shall contain, but not be limited to, the following:

(1) Date of initial contact requesting services;

(2) Identification information, including Patient's name, home address, and telephone number;

(3) Referral source;

(4) Mental status examination and findings;

(5) History and physical information;

(6) Family to be notified in case of emergency; and

(d) Compliance with 450:70-3-5.7 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.8. Intake assessment and record content - ASAM**

(a) The OTP shall document and assess all patients for appropriateness of admission taking into account the patient's needs as identified by, but not limited to:

(1) Acute intoxication and withdrawal potential;

(2) Biomedical conditions and complications;

(3) Emotional and behavioral conditions and complications;

(4) Readiness to change;

(5) Relapse potential; and

(6) Recovery environment.

(b) Compliance with 450:70-3-5.8 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.9. Intake assessment and record content - Supportive service array**

(a) The OTP shall have a written policy and procedure that shall be made available to all patients, outlining rehabilitation services. Minimum services include:

(1) Individual counseling until the patient is fully stabilized and as indicated in this chapter;

(2) Group and family counseling for spouses, parents, or significant others and as indicated in this chapter;

(3) Vocational or educational counseling and referral and as indicated in this chapter; and

(4) Referral for additional services as outlined by the individualized treatment plan.

(b) Compliance with 450:70-3-5.9 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.10. Intake assessment and record content - Service notification**

(a) The OTP shall have written policy and procedure requiring the patient to be informed of all services that are available through the agency; and of all policies and procedures that may impact the patient's treatment.

(b) There shall be written verification such notification was made, signed by the patient.

(c) The OTP shall have written policy and procedure requiring the patient be informed of the following upon admission:

(1) The progression of opioid dependence and the patient's assessed stage of opioid dependence;

(2) The goal and benefits of medication assisted opioid treatment;

(3) The signs and symptoms of overdose and when to seek emergency assistance;

(4) The characteristics of opioid agonist and partial agonist treatment medication, including common side-effects and potential interaction effects with non-opioid agonist treatment medications and/or illicit drugs;

(5) The requirement for staff members to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult;

(6) The requirement for staff members to comply with the confidentiality requirements of 42 CFR Part 2 and 45 CFR parts 160 and 164;

(7) Drug screening and urinalysis procedures;

(8) Take-home medication requirements;

(9) Testing and treatment available for HIV, HCV, tuberculosis and other communicable diseases;

(10) The process for a patient to file a grievance with the agency for any reason, including involuntary discharge, and to have the client's grievance handled in a fair and timely manner; and

(11) The process for a patient to file a grievance with the ODMHSAS Patient Advocate office agency for any reason, including involuntary discharge.

(d) Compliance with 450:70-3-5.10 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.11. Intake assessment and record content - Chronic pain**

(a)The OTP shall have written policy and procedure requiring the OTP to see that an individual who requires administration of opioid agonist treatment and partial agonist medication only for relief of chronic pain is:

(1) Identified during the physical examination or assessment;

(2) Not admitted for opioid agonist or partial agonist medication treatment; and

(3) Referred to appropriate medical services.

(b) Compliance with 450:70-3-5.11 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.12. Intake assessment and record content - Co-occurring disorder**

(a) The OTP shall have written policy and procedure requiring the facility to ensure that, if, during the assessment or physical examination, a determination is made that a patient may have a mental disorder, the patient is referred for assessment and treatment of the mental disorder.

(b) All required consents, for communication and collaboration with the patient's behavioral health professional to monitor and evaluate interactions between the client's opioid agonist or partial agonist treatment medication and any medications used to treat the patient's mental disorder are required to be completed and in the chart.

(c) Compliance with 450:70-3-5.12 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.13. Intake assessment and record content - Medical**

(a) The OTP shall have written policy and procedure requiring the OTP to ensure that, if, during the assessment or physical examination, a determination is made that a patient may have a medical condition requiring intervention, the patient is referred for assessment and treatment of the medical condition.

(b) The OTP will have all required consents, for communication and collaboration with the patient's health professional to monitor and evaluate interactions between the patient's opioid agonist or partial agonist treatment medication and medications used to treat the patient's medical condition.

(c) Compliance with 450:70-3-5.13 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.14. Intake assessment and record content - Medical service refusal**

(a) The OTP shall have written policy and procedure allowing the medical director to refuse the admission and/or medication assisted opioid treatment to any patient if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

(b) Compliance with 450:70-3-5.14 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.15. Intake assessment and record content - Identification**

(a) The OTP shall have written policy and procedure requiring the patient must present a valid form of photo identification which can include;

(1) A valid, State authorized driver's license from the State of residence,

(2) A valid federally authorized form of identification card, or

(3) A valid Tribal ID card with photograph from a federally recognized tribe.

(b) Photocopies shall be obtained upon admission and the copy must be maintained in the patient's record. The program shall document in the patient's file attempts to induce the patient to obtain state identification.

(c) Compliance with 450:70-3-5.15 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.16. Intake assessment and record content - Initial dosing**

(a) OTPs shall develop and maintain written policies and procedures that are adequate to ensure that the following dosage form and initial dosing requirements are met:

(1) Methadone shall be administered or dispensed only in oral and liquid form and shall be formulated in such a way as to reduce its potential for parenteral abuse. Diskettes shall be dissolved in liquid prior to being dispensed, or dissolved in liquid.

(2) For each new patient enrolled in a program, the initial dose of methadone shall not exceed thirty (30) milligrams and the total dose for the first day shall not exceed

forty (40) milligrams, unless the program physician documents in the patient's record that forty (40) milligrams did not suppress opiate abstinence symptoms.

(3) Any increase above forty (40) milligrams shall be based on the physician's medical judgment and documented in the chart.

(4) Buprenorphine may be administered in tablet or sublingual form.

(5) Initial and later treatment dosing shall be determined by the medical director and according to best medical practice.

(b) Compliance with 450:70-3-5.16 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-5.17. Intake assessment and record content - Patient service refusal**

(a) The OTP Shall ensure that a patient's refusal of a particular service does not preclude the patient from accessing other needed mental health or substance abuse services. Should the service provider determine the patient's needs cannot be met within the facility, clinical documentation of assessments and referrals for the patient shall contain, at a minimum:

(1) Date of initial contact requesting services;

(2) Identification information, including Patient's name, home address and telephone number;

(3) Referral source;

(4) Mental status examination and results;

(5) History and physical;

(6) Family to be notified in case of emergency;

(7) A continuing care plan;

(8) What agency was contacted; and

(9)Where and why the individual was referred.

(b) Compliance with 450:70-3-5.16 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-3-6. Intake and assessment, process requirements**

(a) Written policies and procedures governing the intake and assessment process shall specify the following:

(1) The information to be obtained on all applicants or referrals for admission;

(2) The procedures for accepting referrals from outside agencies or organizations;

(3) The records to be kept on all applicants;

(4) Any prospective patient data to be recorded during the intake process;

(5) The procedures to be followed when an applicant or a referral is found ineligible for admission; and

(6) The procedures and policies for the purpose of admitting and assessing persons with special needs or disabilities.

(b) Compliance with 450:70-3-5.16 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

## PART 5. BIOPSYCHSOCIAL ASSESSMENT

**450:70-3-7. Biopsychsocial assessment**

(a) All ~~OSTPs~~OTPs shall complete a biopsychsocial assessment which gathers sufficient information to assist the patient in developing an individualized treatment plan. The ~~OSTP~~OTP~~shall~~ may utilize the current edition of the Addiction Severity Index (ASI) or develop a biopsychsocial assessment which contains, but not be limited to, the following:

(1) Identification of the patient's strengths, needs, abilities, and preferences ~~problem~~;

(2) Presenting problem and history of the presenting problem;

(3) Previous treatment history, including opioid substitution therapy:

(A) Mental health,

(B) Substance abuse, and

~~(C) Domestic violence, to include batterer's treatment or victim services;~~

(4) Health history and current biomedical conditions and complications;

(5) Alcohol and drug use history;

(6) History of trauma;

(7) Family and social history, including family history of alcohol and drug use;

(8) Educational attainment, difficulties, and history;

(9) Cultural and religious orientation;

(10) Vocational, occupational and military history;

(11) Sexual history, including HIV, AIDS and STD at-risk behaviors;

(12) Marital or significant other relationship history;

(13) Recreational and leisure history;

(14) Legal history;

(15) Present living arrangement;

(16) Economic resources;

(17) Level of functioning;

(18) Current support system;

(19) Current medications, ~~if applicable and shall include obtainable information regarding~~ including the name of prescribing physician, name of medication, strength and dosage, and length of time the consumer has been~~was~~ on the medication;

(20) Patient's expectations in terms of service; and

(21) Assessment summary or diagnosis, and signature of the assessor and date of the assessment.

(b) The assessment shall be completed as soon as possible after admission and ~~by the end of fourth (4th)~~no later than the third (3) counseling visit.

(c) In the event of a consumer re-admission after one (1) year of the last biopsychsocial assessment, a new biopsychsocial assessment shall be completed. If readmission occurs within one (1) year after the last biopsychsocial assessment, an update shall be completed.

(d) Compliance with 450:70-3-7 may be determined by:

(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

## PART 7. ~~TREATMENT~~ SERVICE PLANNING

### 450:70-3-8. Individualized ~~treatment~~ service planning

(a) Upon completion of the admission evaluation, an individualized ~~treatment~~ service plan shall be developed. The individualized ~~treatment~~ service plan shall include, but not be limited to:

(1) Presenting problems or diagnosis;
(2) Strengths, needs, abilities, and preferences of the patient;
(3) Goals for treatment with specific, measurable, attainable, realistic and time-limited;
(4) Type and frequency of services to be provided;
(5) ~~Primary person responsible for providing services~~ Dated signature of primary service provider;
(6) Description of patient's involvement in, and responses to, the ~~treatment~~ service plan, and his or her signature and date;
(7) Individualized ~~D~~discharge criteria or maintenance;
~~(8) Specific date for each planned treatment plan review and update, no less than at each phase change;~~
~~(9) Any other item required by state of federal law;~~
(~~10~~8) Projected length of treatment;
~~(11) Medication Protocol;~~
(~~12~~9) Measurable long and short term treatment goals;
(~~13~~10) Primary and supportive services to be utilized with the patient;
(~~14~~11) Type and frequency of therapeutic activities in which patient will participate;
(~~15~~12) Documentation of the patient's participation in the development of the plan; and
(~~16~~13) Staff who will be responsible for the patient's treatment.

(b) The ~~treatment~~ service plan shall be based on the patient's presenting problems or diagnosis, intake assessment, biopsychsocial assessment, and expectations of their recovery.

~~(c) Treatment plans shall be dated and signed by the patient and the primary service provider. A list of the treatment team members who participate in providing services shall be included on the treatment plan.~~

(~~d~~c) ~~Unless otherwise indicated by this chapter, f~~Frequency of services shall be determined by mutual agreement between the facility treatment team and the patient.

(~~e~~d) ~~Time frames for completion of treatment~~ service plans ~~from the date and time of admission~~ shall be completed by the ~~sixth (6th)~~ fourth (4) counseling visit after admission.

(~~f~~e) The ~~treatment~~ service plan ~~shall contain~~ review ~~and update of the treatment plan~~ should occur according to the time frame required by the ~~treatment plan~~ agency but, no less often than every six (6) months; and further, is required by any of the following situations:

(1) Change in goals and objectives based upon patient's documented progress, or identification of any new problem;
(2) Change in primary counselor assignment;
(3) Change in frequency and types of services provided;
(4) Critical incident reports; ~~or~~
(5) Sentinel events~~.~~; or
(6) Phase change.

(f) Each patient accepted for treatment shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment. The service plan also must identify the frequency and intensity of services to be provided.

(g) The plan must be reviewed and updated to reflect that patient's personal history, current needs for medical, social, and psychological services, and current needs for education, vocational rehabilitation, and employment services.

(h) The OTP will provide adequate and appropriate counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate service plan for the patient and to monitor patient progress.

(i) Compliance with 450:70-3-8 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

## PART 9. PROGRESS NOTES

### 450:70-3-9. Progress notes

(a) Unless defined otherwise by level of care, medication assisted opioid ~~substance abuse~~ treatment services and any issues related to treatment shall be reflected by written documentation in the patient's record and shall include the following:

(1) date;
(2) start and stop time for each timed treatment session;
(3) dated signature of the staff person providing the service ~~and date of signature~~;
(4) credentials of the staff person providing the service;
(5) when service is provided by a paraprofessional, signatures of the paraprofessional and a credentialed staff person;
(6) specific ~~problems(s)~~ service plan needs, goals and/or objectives addressed ~~(problem must be identified on master treatment plan, or the assessment)~~;
(7) interventions used to address problem(s), goals and objectives;
(8) progress made toward goals and objectives, or lack of;
(9) patient response to the session or intervention;
(10) any new problem(s), goals and objectives identified during the session~~; and~~.
~~(11) Patient's name and unique identifier.~~

(b) Compliance with 450:70-3-8 may be determined by:

(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

## PART 11. DISCHARGE

**450:70-3-10. Discharge assessment**

(a) All consumers shall be assessed for biopsychsocial appropriateness of discharge from each level of care ~~taking into account the consumers needs as identified by, but not limited to~~ using ASAM PPC that includes a list of symptoms for all six dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination for appropriate placement to a specific level of care based on the consumer's severity of symptoms and current situations.

~~(1) Presenting problem(s) at intake;~~
~~(2) Initial condition and condition of consumer at discharge;~~
~~(3) Medication summary, when appropriate;~~
~~(4) Treatment and services provided, and a summary of treatment outcomes and results;~~
~~(5) The continuing care plan may be included in the discharge summary;~~
~~(6) The signature of the staff member completing the summary, and the date;~~
(~~7~~1) Acute intoxication and/or withdrawal potential;
(~~8~~2) Biomedical conditions and complications;
(~~9~~3) Emotional, behavioral or cognitive conditions and complications;
(~~10~~4) Readiness to change;
(~~11~~5) Relapse, continued use or continued problem potential; and
(~~12~~6) Recovery/living environment.

~~(b) A discharge summary shall be entered in each patient's record within fifteen (15) days of discharge.~~

(b) Compliance with 450:70-3-10 may be determined by:
(1) A review of policies and procedures, and
(2) Discharge assessments in patient records.

**450:70-3-10.1. Discharge summary/continuing care plan**

(a) The discharge summary shall at a minimum include**:**
(1) Presenting problem(s) at intake;
(2) Initial condition and condition of patient at discharge;
(3) Medication summary, if the patient is taking medications;
(4) Treatment and services provided, and a summary of treatment outcomes;
(5) Specific referrals for continuing services and needed resources;
(6) The patient's response to the services received or an explanation explaining no response; and
(7) The signature of the staff member completing the summary, and the date.
(8) In the event of the death of a patient, a summary statement including this information shall be documented in the record.

(b) A discharge summary shall be entered in each patient's record within fifteen (15) days of discharge.

(c) Compliance with 450:70-3-10 may be determined by:
(1) A review of policies and procedures, and
(2) Discharge assessments in treatment records.

## SUBCHAPTER 4. SERVICES SUPPORT AND ENHANCEMENT

## PART 1. STAFF SUPPORT

**450:70-4-1. Purpose [REVOKED]**

~~The purpose of this subchapter is to set forth components which support and enhance treatment services provided to consumers by OSTP staff and employees.~~

**450:70-4-2. Clinical supervision**

(a) All ~~facilities~~ OTPs shall provide clinical supervision for those delivering direct services and shall be provided by persons qualified to provide clinical supervision as determined by state licensure or certification.

(b) All ~~facilities~~ OTPs shall have written policy and procedures, operational methods, and documentation regarding clinical supervision for all direct treatment staff and service staff. These policies shall include, but are not limited to:
(1) Credentials required for the clinical supervisor;
(2) Specific frequency for case reviews with treatment and service providers;
(3) Methods and time frames for supervision of individual, group, and educational treatment services; and
(4) Written policy and procedures defining the program's plan for appropriate counselor-to-patient ratio, and a plan for how exceptions may be handled.

(c) Ongoing clinical supervision should address:
(1) The appropriateness of ~~treatment~~services selected for the patient;
(2) ~~Treatment~~ Service effectiveness as reflected by the patient meeting ~~their~~ his/her individual goals; and
(3) The provision of feedback that enhances the clinical skills of direct service staff and ~~treatment professionals~~ service providers.

(d) Compliance with 450:70-4-2 may be determined by:
(1) A review of policies and procedures,
(2) Clinical services manuals,
(3) Clinical supervision manuals,
(4) Documentation of clinical supervision,
(5) Personnel records,
(6) Treatment records,
(7) Interviews with staff; and
(8) Other facility documentation.

**450:70-4-3. Staff privileging**

(a) Each ~~OSTP~~OPT shall have policy and procedure for documenting and verifying the training, experience, education, and other credentials of ~~treatment professionals~~service providers prior to their providing clinical ~~or treatment~~ services.

(b) Each ~~OSTP~~OTP shall have written policy and procedures and operational methods for evaluating the professional qualifications of ~~treatment professionals~~service providers providing ~~treatment~~ clinical services, including those who perform staff privileging evaluations and the verification process, and the granting of privileges.

(c) All ~~treatment professionals~~service providers shall be documented as privileged prior to performing ~~treatment~~ clinical services.

(d) The evaluation and verification of professional qualifications includes, but is not limited to, the review and verification of:

(1) Professional degree(s) via official college transcript(s);

(2) Professional licensure(s);

(3) Professional certification(s);

(4) Professional training;

(5) Professional experience; and

(6) Other qualifications as set forth in the position's job description.

(e) Each ~~OSTP~~OTP shall minimally perform an annual review of current licensure, certifications, and current qualifications for privileges to provide specific treatment services.

~~(f) Initial training and ongoing training updates for all personnel employed by the treatment facility covers at a minimum:~~

~~(1) Rights of the patients served;~~

~~(2) Person and family centered services;~~

~~(3) The prevention of violence in the workplace;~~

~~(4) Confidentiality requirements;~~

~~(5) Cultural competency; and~~

~~(6) Expectations regarding professional conduct.~~

(f) Compliance with 450:70-4-3 may be determined by:

(1) A review of policies and procedures,

(2) Clinical supervision manuals,

(3) Personnel records,

(4) Privileging documents,

(5) Interviews with staff, and

(6) Other facility documentation

**450:70-4-4. Staffing - Dosing coverage**

(a) The ~~OSTP~~OTP shall have written policy and procedure requiring at least two (2) staff members be present on the premises during dispensing hours. At least one (1) of the staff members shall be appropriately licensed to dispense approved opioid agonist or partial agonist drugs.

~~(b) The OSTP shall have written policy and procedure to ensure that only appropriately trained and licensed medical personnel shall be allowed access to, transportation of, dispensing of, administration of, or responsibility for opioid medications.~~

~~(1) Access to medication deliveries to an OSTP shall be received, secured and inventoried by program personnel specifically designated for this task.~~

~~(2) Acceptance of delivery of narcotic substances must be made only by a licensed practitioner employed at the OSTP or other authorized individuals designated in writing who must sign for the narcotics. Staff who are currently or previously dependent on narcotic drugs are not allowed to perform this function.~~

~~(3) The OSTP shall have one staff member to have primary responsibility for receiving, securing and inventorying medications.~~

~~(4) The OSTP also shall identify additional program personnel who have authority to receive, store and inventory the medication at times when the individual designated to have primary responsibility is not available.~~

~~(5) The OSTP shall maintain a written list of all designated personnel who have been authorized to receive, store and inventory the medication. This list shall be updated whenever a change in designated personnel occurs.~~

~~(c) Transportation of opioid medications by OSTP staff shall also:~~

~~(1) Be limited to OSTP patients in residential treatment or jail, and~~

~~(2) Always done with an appropriate chain of custody form, such as the one available through the Division of Pharmacologic Therapies within SAMHSA.~~

~~(d) The OSTP shall have written policy and procedure requiring the Medical Director be present, on site for two hours each week during normal dispensing hours for every one hundred (100) patients admitted to an OSTP.~~

~~(e) The OSTP shall have written policy and procedure requiring each person engaged in the treatment of opioid addiction to have sufficient education, training, and/or experience to enable that person to perform the assigned duties and functions. This includes specific training in opioid related treatment options. All physicians, nurses, and other licensed professional care providers, including addiction counselors, must comply with the credentialing requirements of their respective professions. Hiring preference may be given to staff with addiction and/or opioid treatment specific licenses and certifications.~~

~~(1) All direct service and medical staff shall receive training relevant to service delivery in an opioid treatment setting. There shall be~~

~~(2) Each staff member shall have documentation in a personnel file of participation in fourteen (14) clock hours of such training during each two (2) year period.~~

~~(3)~~ It is recommended that physicianshave, or be in the process of obtaining, specialty certification and/or licensure related to opioid treatment.

~~(f) The OSTP shall have written policy and procedure requiring opioid agonist treatment medications be administered or dispensed only by a practitioner licensed and registered under the appropriate State and Federal laws to administer or dispense opioid drugs.~~

~~(g) The facility shall maintain documentation verifying the qualifications for the treatment professionals.~~

~~(h) Staff shall be, at least, twenty one (21) years old (excluding student interns).~~

(b) Compliance with 450:70-4-4 may be determined by:

(1) a review of policies and procedures,

(2) staff schedules,
(3) treatment records, and
(4) other facility documentation.

**450:70-4-4.1. Staffing - Transportation, dispensing and responsibility**

(a) The OTP shall have written policy and procedure to ensure that only appropriately trained and licensed medical personnel shall be allowed access to, transportation of, dispensing of, administration of, or responsibility for approved opioid agonist or partial agonist medications.

(1) Access to medication deliveries to an OTP shall be received, secured and inventoried by program personnel specifically designated for this task.

(2) Acceptance of delivery of scheduled drugs must be made only by a licensed practitioner employed at the OTP or other authorized individuals designated in writing who must sign for all scheduled drugs. Staff who are currently or previously dependent on opioids are not allowed to perform this function.

(3) The OTP shall have one staff member to have primary responsibility for receiving, securing and inventorying medications.

(4) The OTP also shall identify additional program personnel who have authority to receive, store and inventory the medication at times when the individual designated to have primary responsibility is not available.

(5) The OTP shall maintain a written list of all designated personnel who have been authorized to receive, store and inventory the medication. This list shall be updated whenever a change in designated personnel occurs.

(b) Transportation of opioid medications by OTP staff shall also:

(1) Be limited to OTP patients in residential treatment, hospital, long term care or jail, and

(2) Always done with an appropriate chain of custody form, such as the one available through the Division of Pharmacologic Therapies within SAMHSA.

(c) Compliance with 450:70-4-4.1 may be determined by:

(1) A review of policies and procedures,
(2) Personnel records,
(3) Privileging documents,
(4) Training records,
(5) Interviews with staff, and
(6) Other facility documentation.

**450:70-4-4.2. Staffing - Medical Director coverage**

(a) The OTP shall have written policy and procedure requiring the medical director be present, on site for two hours each week during normal dispensing hours for every one hundred (100) active patients in an OTP. In this instance, a designee cannot substitute for the medical director.

(b) For this standard, substituting a program physician, physician assistant or certified nurse practitioner for the medical director is not sufficient.

(c) Compliance with 450:70-4-4.2 may be determined by:

(1) A review of policies and procedures,
(2) Staff schedules,
(3) Privileging documents,
(4) Employee contracts,
(5) Interviews with staff, and
(6) Other facility documentation.

**450:70-4-4.3. Staffing - Training**

(a) The OTP shall have written policy and procedure requiring each person engaged in the medication assisted treatment of opioid dependence to have sufficient education, training, and/or experience to enable that person to perform the assigned duties and functions. This includes specific training in opioid related treatment options. All physicians, nurses, and other licensed professional care providers, including counselors, must comply with the credentialing requirements of their respective professions. Hiring preference may be given to staff with substance use disorder and/or opioid treatment specific licenses and certifications.

(1) All direct service and medical staff shall receive training relevant to service delivery in a medication assisted opioid treatment setting. There shall beseven (7) clock hours of such training during each year.

(2) All direct service staff shall receive initial training and ongoing training updates for all personnel employed by the treatment facility covers at a minimum:

(A) Rights of the patients served;
(B) Person and family centered services;
(C) The prevention of violence in the workplace;
(D) Confidentiality requirements;
(E) Cultural competency; and
(F) Expectations regarding professional conduct.

(3) All physicians working in an OTP should have, or be in the process of obtaining, specialty certification and/or licensure related to medication assisted opioid and/or substance use disorder treatment.

(b) Compliance with 450:70-4-4.3 may be determined by:

(1) A review of policies and procedures,
(2) Credentialing and privileging documents,
(3) Training records,
(4) Interviews with staff, and
(5) Other facility documentation.

**450:70-4-4.4. Staffing - Qualifications**

(a) The OTP shall have written policy and procedure requiring opioid agonist or partial agonist treatment medications be administered or dispensed only by a practitioner licensed and registered under the appropriate State and Federal laws to administer or dispense such drugs.

(b) The facility shall maintain documentation verifying the qualifications for the service providers.

(c) Staff shall be, at least, twenty one (21) years old (excluding student interns).

(d) Compliance with 450:70-4-4.4 may be determined by:

(1) A review of policies and procedures,
(2) Credentialing and privileging documents,
(3) Interviews with staff, and
(4) Other facility documentation.

## PART 3. ORGANIZATIONAL AND FACILITY MANAGEMENT

### 450:70-4-5. Service support and Enhancement

(a) Each ~~OSTP~~OTP shall have written policies and procedures describing operational methods, administration and organization adequate to ensure quality patient care, ability to operate in accordance with all approved accreditation elements and to meet the requirements of all pertinent Federal, State and local laws and regulations. In addition an ~~OSTP~~OTP will operate in accordance with all approved accreditation elements; including the ~~Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD), the Drug Enforcement Agency (DEA), and the Substance Abuse Mental Health Services Administration (SAMHSA)~~OBNDD, DEA and SAMHSA.

(b) ~~OSTPs~~OTPs will produce evidence of a current and valid certification from SAMHSA to be considered qualified to dispense opioid drugs in the treatment of opioid dependence. Prior to beginning the delivery of medication assisted opioid treatment services, an ~~OSTP~~OTP must apply for and receive ~~temporary certification~~a permit for temporary operations from ODMHSAS.

(c) An ~~OSTP~~OTP must produce evidence that the program has been determined under the Controlled Substances Act to be qualified and registered to dispense opioid agonist treatment medications to individuals for treatment of opioid dependence.

(d) In order to retain ODMHSAS certification an ~~OSTP~~OTP shall produce within twelve (12) months of opening, a current, valid accreditation by an accreditation body or other entity designated by SAMHSA such as ~~Commission for the Accreditation of Residential Facilities (CARF), the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), or the Commission on Accreditation (COA)~~CARF, JCAHO, or COA including a written description of the current accreditation status of the ~~OSTP~~OTP and must comply with any additional conditions for certification established by SAMHSA.

~~(e) An OSTP shall have an accurate and current description of organizational structure including;~~

~~(1) The names and contact information of all persons responsible for the OSTP.~~

~~(2) The current addresses of the OSTP and of each additional facility, medication unit or additional site under the control of the OSTP providing opioid agonist treatment, and~~

~~(3) The sources of any funding other than patient fees for the OSTP including the name and address of any governmental entity that provides such funding.~~

~~(f) Each OSTP shall formally designate a program sponsor and medical director.~~

~~(1) The program sponsor shall agree in writing on behalf of the OSTP to adhere to all requirements set forth in this chapter and any regulations regarding the use of opioid agonist treatment medications in the treatment of opioid addiction which may be promulgated in the future.~~

~~(2) The medical director shall agree in writing to assume responsibility for administration of all medical services performed by the OSTP. In addition, the medical director shall be responsible for ensuring that the OSTP is in compliance with all applicable Federal, State, and local laws and regulations.~~

~~(g) The OSTP shall have a written organizational description, which is reviewed annually and minimally includes:~~

~~(1) The overall target population for whom services will be provided;~~

~~(2) The overall mission statement;~~

~~(3) The annual facility goals and objectives; and~~

~~(4) Documentation that these statements have been approved by the OSTP's governing authority.~~

~~(h) The OSTP shall have documentation demonstrating the documents listed in section (i), (1) through (4) above are available and communicated to staff.~~

~~(j) The OSTP shall have documentation demonstrating the documents listed in section (k), (1) through (4) above are available to the general public upon request.~~

~~(l) Each OSTP shall have in writing, by program component or service, the following:~~

~~(1) A description of the program;~~

~~(2) The philosophy of the program;~~

~~(3) Program goals and objectives;~~

~~(4) Identification of treatment professionals to provide these services; and~~

~~(5) Admission and exclusionary criteria to identify the type of consumers for whom the services are primarily intended.~~

~~(m) A written statement of the procedures and plans for attaining the facility goals and objectives. These procedures and plans should define specific tasks, set target dates and designate staff responsible for carrying out the procedures and plans.~~

~~(n) An OSTP shall notify the SMA within one (1) work day of any vacancy or replacement or other change in the status of the program sponsor or medical director.~~

~~(o) An OSTP, medication unit, or any part thereof including any related facility or individual shall allow inspections and surveys by duly authorized employees of ODMHSAS, SAMHSA, the accreditation body providing national accreditation, the DEA, and by authorized employees of any other relevant State or Federal governmental authority.~~

~~(p) OSTPs shall notify the SMA plans to either close, or relocate the program not less than thirty (30) days prior to said closure, or relocation. Relocation shall be contingent upon ODMHSAS certification of any new treatment location.~~

~~(q) Each OSTP must notify the SMA in writing of clinic closure due to holidays, training prior to the date, and as soon after the event as possible in the case of emergencies.~~

~~(r) The OSTP shall have written policy and procedure establishing a standard fee for patients that shall be inclusive of all regular and normal, clinical, administrative and medical services and procedures and be no more than $65.00 per week.~~

~~(s) Unless otherwise specified in this chapter, requirements, and exceptions, for each type of opioid treatment services shall apply, as required by 42 CFR, Chapter 1, Part 8.~~

~~(t) Each OSTP shall have written policy and procedure stating that programs in the same geographical area shall develop policy and procedure designed to work together to maximize hours of operation and treatment accessibility.~~

~~(u) The OSTP shall have available specialized professional consultation or professional supervision.~~

(e) Compliance with 450:70-4-5 may be determined by:

(1) A review of policies and procedures,

(2) Current certifications, accreditations, registrations, and licenses, and

(3) Other facility documentation.

**450:70-4-5.1. Organizational - Staffing**

(a) An OTP shall have an accurate and current description of organizational structure including;

(1) The names and contact information of all persons responsible for the OTP.

(2) The current addresses of the OTP and of each additional facility, medication unit or additional site under the control of the OTP providing opioid agonist treatment, and

(3) The sources of any funding other than patient fees for the OTP including the name and address of any governmental entity that provides such funding.

(b) Each OTP shall formally designate a program sponsor and medical director.

(1) The program sponsor shall agree in writing on behalf of the OTP to adhere to all requirements set forth in this chapter and any regulations regarding the use of opioid agonist or partial agonist treatment medications in the treatment of opioid dependence which may be promulgated in the future.

(2) The medical director shall agree in writing to assume responsibility for administration of all medical services performed by the OTP. In addition, the medical director shall be responsible for ensuring that the OTP is in compliance with all applicable Federal, State, and local laws and regulations.

(c) Compliance with 450:70-4-5.1 may be determined by:

(1) A review of policies and procedures, and

(2) Other facility documentation.

**450:70-4-5.2. Organizational - Structure and documentation**

(a) The OTP shall have a written organizational description, which is reviewed annually and minimally includes:

(1) The overall target population for whom services will be provided;

(2) The overall mission statement;

(3) The annual facility goals and objectives; and

(4) Documentation that these statements have been approved by the OTP's governing authority.

(b) The OTP shall have documentation demonstrating the documents listed in section (a), (1) through (4) above are available and communicated to staff.

(c) The OTP shall have documentation demonstrating the documents listed in section (a), (1) through (4) above are available to the general public upon request.

(d) Each OTP shall have in writing, by program component or service, the following:

(1) A description of the program;

(2) The philosophy of the program;

(3) Program goals and objectives;

(4) Identification of service providers to provide these services; and

(5) Admission and exclusionary criteria to identify the type of patients for whom the services are primarily intended.

(e) A written statement of the procedures and plans for attaining the facility goals and objectives. These procedures and plans should define specific tasks, set target dates and designate staff responsible for carrying out the procedures and plans.

(f) Compliance with 450:70-4-5.2 shall be determined by:

(1) A review of the facility's target population definition,

(2) Facility policy and procedures,

(3) Mission statement,

(4) Written plan for professional services,

(5) Other stated required documentation, and

(6) Other facility documentation.

**450:70-4-5.3. Organizational - Notification of ODMHSAS**

(a) An OTP shall notify the SOTA within one (1) work day of any vacancy or replacement or other change in the status of the program sponsor or medical director.

(b) An OTP, medication unit, or any part thereof including any related facility or individual shall allow inspections and surveys by duly authorized employees of ODMHSAS, SAMHSA, the accreditation body providing national accreditation, the DEA, and by authorized employees of any other relevant State or Federal governmental authority.

(c) OTPs shall notify the SOTA of plans to either close, or relocate the program not less than thirty (30) days prior to said closure, or relocation. Relocation shall be contingent upon ODMHSAS certification of any new treatment location.

(d) Each OTP must notify the SOTA in writing of clinic closure due to holidays, training prior to the date, and as soon after the event as possible in the case of emergencies.

(e) Compliance with 450:70-4-5.3 may be determined by:

(1) A review of policies and procedures,

(2) Interviews with staff, and

(3) Other facility documentation.

**450:70-4-5.4. Organizational - Fee structure and exceptions**

(a) The OTP shall have written policy and procedure establishing a standard fee for patients receiving methadone as part of a medication assisted treatment program that shall be inclusive of all regular and normal, clinical, administrative and medical services and procedures and be no more than $65.00 per week.

(b) Unless otherwise specified in this chapter, requirements, and exceptions, for each type of opioid treatment services shall apply, as required by 42 CFR, Chapter 1, Part 8.

(c) The fee for patients receiving buprenorphine as part of a medication assisted treatment program shall be set by the OTP medical director.

(d) Compliance with 450:70-4-5.4 may be determined by:

(1) A review of policies and procedures,
(2) Interviews with staff, and
(3) Other facility documentation.

**450:70-4-5.5. Organizational - Cooperative agreements**

(a) Each OTP shall have written policy and procedure stating that programs in the same geographical area shall develop policy and procedure designed to work together to maximize hours of operation and treatment accessibility.

(b) Compliance with 450:70-4-5.5 may be determined by:
(1) A review of policies and procedures,
(2) Interviews with staff, and
(3) Other facility documentation.

**450:70-4-5.6. Organizational - Consultation**

(a) The OTP shall have available specialized professional consultation or professional supervision.

(b) Compliance with 450:70-4-6 may be determined by:
(1) A review of policies and procedures,
(2) Interviews with staff, and
(3) Other facility documentation.

**450:70-4-6. New program approval**

(a) Determination of the need for new services shall be at the sole discretion of ODMHSAS as the designated state authority responsible for medication assisted opioid ~~substitution~~ treatment through information provided by the proposed new agency including:

(1) Copies of all planned promotional materials, advertisements, and marketing strategies to publicize the proposed program;

(2) Policies and procedures that will be used to identify if a patient is enrolled in another clinic;

(3) The source and adequacy of financial assets necessary to operate the program;

(4) If applicable, the compliance history of the applicant, including any issues reported to ODMHSAS by SAMHSA, DEA or any other regulatory agency;

(5) Adequate planning and organizational structure demonstrated by full and complete answers submitted to all questions in the application materials;

(6) A written statement that the applicant has read, understood and agreed to follow all federal and state regulations concerning operation of an ~~OSTP~~OTP signed by the program sponsor and the medical director;

(7) Document the need for new services in the area as demonstrated by providing ODMHSAS with waiting lists, numbers of opioid related emergency room visits, opioid related arrest data, and federal drug use forecasting data;

~~(8) Demonstrate community acceptance with letters from local residents within one (1) mile of the proposed site(s). Written assurance must be provided to ODMHSAS of local community acceptance; and~~

(~~9~~8) Demonstrate general community acceptance by providing ODMHSAS with copies of letters of support from local authorities and local residents living near the site; and

(9) Produce written documentation that ODMHSAS has received and accepted all the requirements listed above.

(b) Compliance with 450:70-4-7 may be determined by:
(1) A review of policies and procedures,
(2) On-site verification of hours posted,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-4-7. Operations - Hours**

(a) The ~~program~~ OTP shall have policy and procedure to define operations for a minimum of forty (40) hours per week, (excluding holidays and emergency closure) in outpatient settings and twenty-four (24) hours per day in inpatient and residential program settings.

(b) The ~~OSTP~~OTP shall have written policy and procedure for medication dispensing available six (6) days per week in outpatient settings; and seven (7) days per week in inpatient and residential settings with approval from SAMHSA.

(c) The facility shall be publicly accessible and accommodate office space, individual and group counseling space, secure record storage, protect consumer—confidentiality, and provide a safe, warm, welcoming, culturally and age appropriate environment.

(d) Hours of operation shall be during regularly scheduled times in which services are accessible to consumers and the general public, including those employed between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. To accomplish this, the ~~OSTP~~OTP shall have written policy and procedure providing at least two (2) hours per day either prior to 9:00 a.m. or after 5:00 p.m. for dispensing medication and counseling services.

(e) For facilities that do not provide twenty-four (24) hour services, the facility's hours of operation shall be conspicuously displayed on the outside of the building. For facilities in multi-office buildings, the hours shall be posted either on the building directory or the facility's office door.

(f) Clinical services shall be organized with scheduled treatment sessions that accommodate employed and parenting patients' schedules, and offer treatment services during the day, evening, or weekends.

~~(g) The OSTP shall develop written policy and procedures to maintain security over all stocks of medication, the manner in which it is received, stored and distributed consistent with the regulations of the Drug Enforcement Administration, state and federal law.~~

~~(h) OSTPs must maintain written policies and procedures adequate to identify the theft or diversion of take-home medications to the illicit market, including labeling containers with the OSTP's name, address, and telephone number. Programs also must ensure that take-home supplies are packaged in a manner that is designed to reduce the risk of accidental ingestion, including child resistant containers.~~

~~(i) An OSTP must maintain a written, active "Diversion Control Plan" or "DCP" as part of its quality assurance program that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and that assigns specific responsibility to the medical and~~

~~administrative staff of the OSTP for carrying out the diversion control measures and functions described in the DCP. The DCP shall include:~~

~~(1) Written policy and procedure stating a requirement that treatment and administrative activities be continuously monitored to reduce the risk of diversion,~~

~~(2) Written policy and procedure for stopping identified diversion and for preventing future diversion,~~

~~(3) A written policy and procedure policy requiring employees who are formerly (within two (2) years) addicted to drugs including opioids or alcohol; to be considered risks to the security of drug stocks and shall not have access to the drug stocks or to the drug dispensing area, and~~

~~(4) Written policies and procedures for how staff members who diverts medication are held accountable for the medication diversion.~~

~~(j) The OSTP shall have written policy and procedure stating methadone shall not be provided to a patient who is known to be currently receiving methadone from another OSTP without prior approval from the Commissioner or designee. Patients who are known to be enrolled in more than one OSTP at a time will be forced to choose one clinic for treatment. That patient must then begin treatment as a new patient, including attending the clinic on a daily basis a minimum of six days per week, for a period of six months. The patient must also be reported to the SMA.~~

~~(k) The OSTP shall have written policy and procedure stating the OSTP shall provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV), hepatitis C (HCV) and tuberculosis for each patient admitted or readmitted to maintenance or detoxification treatment.~~

~~(l) The OSTP shall have written policy and procedure stating that methadone shall be dispensed orally and in liquid form only. Non-oral forms and tablet form methadone are prohibited from use.~~

~~(m) Each OSTP shall develop written policies and procedures giving preference to the use of liquid and diskette forms of methadone. Diskettes shall be dissolved in liquid prior to being dispensed, or dissolved in liquid by the patient in full and clear view of OSTP staff.~~

~~(n) OSTPs shall have written policies and procedures adequate to ensure that each opioid agonist treatment medication used by the program is administered and dispensed in accordance with its approved product labeling.~~

~~(o) Written policy and procedure shall reflect that dosing and administration decisions shall be made by a program physician familiar with the most up-to-date product labeling. These procedures must ensure that any significant deviations from the approved labeling, including deviations with regard to dose, frequency, or the conditions of use described in the approved labeling, are specifically documented in the patient's record.~~

~~(p) The OSTP shall have written policy and procedure stating the OSTP shall use only those opioid agonist treatment medications that are approved by the Food and Drug Administration for use in the treatment of opioid addiction. In addition, OSTPs who are fully compliant with the protocol of an investigational use of a drug and other conditions set forth in the application may administer a drug that has been authorized under an investigational new drug application through all applicable Federal law for investigational use in the treatment of opioid addiction.~~

~~(q) The OSTP shall maintain written policy and procedures for handling medical emergencies; and an emergency medical number shall be posted for use by staff.~~

~~(r) Crisis intervention and counseling services shall be available when indicated.~~

~~(s) If the OSTP is closed on Sunday or for holidays, there shall be written policy and procedure describing the process for providing services to and dosing for those patients who are not assessed as appropriate to receive a single take home dose. The Medical Director shall be responsible for determining whether a patient can safely be dispensed opioid treatment drugs for unsupervised use. The basis for the decision shall be, at a minimum, the nine criteria listed in 450:70-4-8 (g), (1) through (9).~~

(g) Compliance with 450:70-4-7 may be determined by:

(1) A review of policies and procedures,

(2) Personnel records,

(3) On-site verification,

(4) Interviews with staff, and

(5) Other facility documentation.

**450:70-4-7.1. Operations - Medication security**

(a) The OTP shall develop written policy and procedures to maintain security over all stocks of medication, the manner in which it is received, stored and distributed consistent with the regulations of the DEA, state and federal law.

(b) OTPs must maintain written policies and procedures adequate to identify the theft or diversion of take-home medications to the illicit market, including labeling containers with the OTP's name, address, and telephone number. Programs also must ensure that take-home supplies are packaged in a manner that is designed to reduce the risk of accidental ingestion, including child-resistant containers.

(c) An OTP must maintain a written, active "Diversion Control Plan" or "DCP" as part of its quality assurance program that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and that assigns specific responsibility to the medical and administrative staff of the OTP for carrying out the diversion control measures and functions described in the DCP. The DCP shall include:

(1) Written policy and procedure stating a requirement that treatment and administrative activities be continuously monitored to reduce the risk of diversion,

(2) Written policy and procedure for stopping identified diversion and for preventing future diversion, and

(3) Written policies and procedures for how staff members who diverts medication are held accountable for the medication diversion.

(d) Compliance with 450:70-4-7.1 may be determined by:

(1) A review of policies and procedures,

(2) Personnel records,
(3) On-site verification,
(4) Interviews with staff, and
(5) Other facility documentation.

**450:70-4-7.2. Operations - Dual enrollments**

(a) The OTP shall have written policy and procedure stating methadone or buprenorphine shall not be provided to a patient who is known to be currently receiving methadone or buprenorphine from another OTP. Patients who are known to be enrolled in more than one OTP at a time shall be required to choose one clinic for treatment. That patient must then begin treatment as a new patient, including attending the clinic on a daily basis a minimum of six days per week, for a period of six months. The patient must also be reported to the SOTA.

(b) Compliance with 450:70-4-7.2 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-4-7.3. Operations - Dosing considerations**

(a) The OTP shall have written policy and procedure stating that methadone shall be dispensed orally and in liquid form only. Non-oral forms and tablet form methadone are prohibited from use. Tablet and sublingual forms of buprenorphine are allowed.

(b) Each OTP shall develop written policies and procedures giving preference to the use of liquid and diskette forms of methadone. Diskettes shall be dissolved in liquid prior to being dispensed, or dissolved in liquid by the patient in full and clear view of OTP staff.

(c) OTPs shall have written policies and procedures adequate to ensure that each opioid agonist and partial agonist treatment medication used by the program is administered and dispensed in accordance with its approved product labeling.

(d) Written policy and procedure shall reflect that dosing and administration decisions shall be made by a program physician familiar with the most up-to-date product labeling. These procedures must ensure that any significant deviations from the approved labeling, including deviations with regard to dose, frequency, or the conditions of use described in the approved labeling, are specifically documented in the patient's record.

(e) The OTP shall have written policy and procedure stating the OTP shall use only those opioid agonist treatment medications that are approved by the Food and Drug Administration for use in the treatment of opioid dependence.

(f) The OTP shall be fully compliant with the protocol of any investigational use of a drug and other conditions set forth in the application may administer a drug that has been authorized under an investigational new drug application through all applicable Federal law for investigational use in the treatment of opioid addiction.

(g) Compliance with 450:70-4-7.3may be determined by:
(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-4-7.4. Operations - Emergencies and exception for weekend dosing**

(a) The OTP shall maintain written policy and procedures for handling medical emergencies; and an emergency medical number shall be posted for use by staff.

(b) Crisis intervention and counseling services shall be available when indicated.

(c) If the OTP is closed on Sunday or for holidays, there shall be written policy and procedure describing the process for providing services to and dosing for those patients who are not assessed as appropriate to receive a single take home dose. The medical director shall be responsible for determining whether a patient can safely be dispensed opioid treatment drugs for unsupervised use. The basis for the decision shall be, at a minimum, the nine criteria listed in 450:70-4-8 (g), (1) through (9).

(d) Compliance with 450:70-4-7.4 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-4-8. Drug testing**

(a) Each OTP shall have written policy and procedure ensuring that an initial drug test is performed for each new patient, including permanent transfer patients, before the initial or maintenance dose is administered. At least monthly random tests are to be performed on each patient in comprehensive maintenance treatment for the initial year of treatment. A minimum of twelve (12) random drug tests annually with no less than one (1) per quarter are required thereafter. All drug testing shall be in accordance with all state and federal law and current drug screen standards.

(1) When a sample is collected from each patient for such test or analysis, it must be done in a manner to produce timely and reliable results.

(2) The OTP must have and follow written procedures for the screening of test samples for all drugs. The procedures shall describe in sufficient detail a plan for collection, storage, handling and analysis of test samples. The procedures shall further describe the program's response to test results that include at least the following:

(A) training for staff members of the importance and relevance of reliable and timely drug abuse test procedures and reports, the purpose of conducting drug tests, and the clinical significance of the results;

(B) A protocol for collection of test samples that minimizes the opportunity for falsification and incorporates the element of randomness;

(C) A protocol for storage of test samples in a secure place to ensure chain of custody and avoid substitution;

(D) A requirement for disclosure of test sample results to the patient and documentation in the patient

record of program and patient response to the test results;

(E) Policy and procedure designed to reduce the negative and/or stigmatizing aspects of drug test collection;

(F) Policy stating that if a patient refuses to provide a test sample, upon request from a staff member, such refusal shall be considered the same as a positive result for illicit drugs. Such refusals shall be documented in the patient record; and

(G) There shall be no "grace period" allowed. Patients from which a UA is requested must submit a sample at that time or it will be considered a refusal.

(b) Compliance with 450:70-4-7.8 may be determined by:

(1) A review of policies and procedures,
(2) Treatment records,
(3) Staff training records,
(4) Interviews with staff, and
(5) Other facility documentation.

**450:70-4-8.1. Drug testing - Detox**

(a) For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug test.

(b) For patients receiving long-term detoxification treatment, the OTP shall perform initial and monthly random tests on each patient as indicated in 450:70-4-8(a).

(c) If the patient has more than one positive urine drug screen in any twelve (12) month period then upon the second positive UA the facility will initiate at least one (1) of the following two (2) items;

(1) Reduce the patient in Phase, or

(2) Initiate an individualized written relapse prevention plan consisting of;

(A) The patient continuing to receive medication assisted opioid treatment as long as such treatment is medically necessary, acceptable to the patient and administrative withdrawal is not indicated,

(B) Address and identify other behavioral issues consistent with relapse in the patient's service plan,

(C) Review the patient's treatment plan and adjust, if necessary, at the first signs of the client's relapse or impending relapse, and

(D) Ensure the client's family members are provided opportunities to be involved in the client's treatment.

(d) Compliance with 450:70-4-8.1 may be determined by:

(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-4-8.2. Drug testing - Required substance identification**

(a) The OTP shall have written policy and procedure stating drug screens will, at a minimum, test for the following substances;

(1) Opioids,
(2) Methadone,
(3) Amphetamines,
(4) Cocaine,
(5) Benzodiazapines,
(6) Barbiturates,
(7) Marijuana.

(b) The OTP shall have written policy and procedure stating drug testing shall include other drugs as may be indicated by the patient's abuse patterns. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each test or analysis must include any such drugs.

(c) The OTP shall have written policy and procedure stating that following admission, the results of a single drug test shall not be the sole basis to determine significant treatment decisions.

(d) Compliance with 450:70-4-8.2 may be determined by:

(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-4-8.3. Unsupervised take-home doses**

(a) The OTP shall have written policy and procedure stating that unsupervised take home use shall be determined by the medical director. In determining which patients may be permitted unsupervised use, the medical director shall consider the following criteria in determining whether a patient is responsible in handling opioid drugs for unsupervised use. The same criteria shall be considered when receiving a patient from a transferring program verifying the amount of time the patient has spent satisfactorily adhering to the criteria found below. This information will be used to determine if the patient shall be allowed to continue the same frequency of clinic attendance permitted at the former program immediately before transferring to the new program. Criteria include but are not limited to:

(1) Absence of recent abuse of drugs (opioid or non-narcotic), including alcohol;
(2) Regular clinic attendance;
(3) Absence of serious behavioral problems at the clinic;
(4) Absence of known recent criminal activity, e.g., drug dealing;
(5) Stability of the patient's home environment and social relationships;
(6) Length of time in comprehensive maintenance treatment;
(7) Assurance that take-home medication can be safely stored within the patient's home;
(8) Whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion; and
(9) The patients current phase in treatment.

(b) The OTP shall have written policy and procedure stating approval for unsupervised use and the basis for such determinations consistent with all criteria shall document such determinations in the patient's medical record.

(c) Compliance with 450:70-4-8.3 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff,
(4) Incident reports, and
(5) Other facility documentation.

**450:70-4-9. Information analysis and planning**

(a) The ~~OSTP~~OTP shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected, to include, but not limited to information from:
(1) Patients;
(2) Governing Authority;
(3) Staff;
(4) Stakeholders;
(5) Outcomes management processes; and
(6) Quality record review.

(b) The ~~OSTP~~OTP shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.

(c) Information collected shall be analyzed to improve patient services and program performance.

(d) The ~~OSTP~~OTP shall prepare an end of year management report, which shall include, but not be limited to:
(1) an analysis of the needs assessment process; and
(2) performance improvement program findings.

(e) The management report shall be communicated and made available to, among others:
(1) the governing authority;
(2) facility staff; and
(3) ODMHSAS, as requested.

(f) Compliance with 450:70-4-9 may be determined by:
(1) A review of program evaluation plans,
(2) Written annual program evaluations,
(3) Special or interim program evaluations,
(4) Program goals and objectives, and
(5) Other supporting documentation provided.

**450:70-4-10. Performance improvement program**

(a) The ~~OSTP~~OTP shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.

(b) The performance improvement program shall address the fiscal management of the ~~OSTP~~OTP.

(c) Each ~~OSTP~~OTP shall identify a performance improvement officer.

(d) The ~~OSTP~~OTP shall document performance improvement activities. These activities shall include, but not be limited to:
(1) Outcomes management specific to each program;
(2) A quarterly quality record review including medical records;
(3) An annual review and revision as appropriate of all program policies and Procedures;
(4) The performance improvement activities shall support increased access to and retention in treatment. ~~The activities shall include a walk through of the intake and admission process. Steps of the walk through include, but are not limited to:~~
~~(A) Select two staff from the facility, including one member of management, to play the roles of "patient" and "family member";~~
~~(B) All staff shall be notified prior to doing the walk through exercise;~~
~~(C) Complete the intake and admission process as defined by OSTP policy as a typical patient and family member would experience; and~~
~~(D) At each step, ask the staff what changes would make it better for the patient and what changes would make it better for the staff. Write all ideas of the staff and participant in the exercise;~~
~~(5) Documentation of the walk through process includes, but is not limited to:~~
~~(A) Note your observations and feelings of participants in this exercise;~~
~~(B) List the process barriers and the improvements that could be made to address these barriers;~~
~~(C) Address the needs from both the patient and staff perspectives; and~~
~~(D) Identify a potential area for change and describe what implementation looked like, how would you know the change would be successful, what changes could be tested to i~~mprove the current process;
(~~6~~5) Staff privileging; and
(~~7~~6) Review of critical and unusual incidents, sentinel events, patient grievances and complaints.

(e) The ~~OSTP~~OTP shall monitor the implementation of the performance improvement plan on an ongoing basis and shall make adjustments as needed.

(f) Performance improvement findings shall be communicated and made available to, among others:
(1) the governing authority,
(2) facility staff,
(3) patients,
(4) stakeholders, and
(5) ODMHSAS, as requested.

(g) Compliance with 450:70-4-10 shall be determined by:
(1) A review of the written program evaluation plan,
(2) Written program evaluations (annual and/or special or interim,
(3) Program goals and objectives (and other supporting documentation provided), and
(4) Other facility documentation.

**450:70-4-11. Critical incidents**

(a) The ~~OSTP~~OTP shall have written policy and procedures for the reporting of every critical incident. Documentation of critical incidents shall minimally include:
(1) The facility, name and signature of the person(s) reporting the incident;

(2) The name(s) of the patient(s), staff member(s) or property involved;
(3) The time, date and physical location of the incident;
(4) The time and date the incident was reported and the name of the staff person within the facility to whom it was reported;
(5) A description of the incident;
(6) Resolution or action taken, description of the action taken, date action was taken, and signature of appropriate staff member(s); and
(7) Severity of each injury, if applicable. Severity shall be indicated as follows:
(A) No off-site medical care required or first aid care administered on-site;
(B) Medical care by a physician or nurse or follow-up attention required; or
(C) Hospitalization or immediate off-site medical attention was required.

(b) Critical incidents shall be reported to ODMHSAS as follows:
(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented.
(2) Critical incidents involving allegations constituting a sentinel event or patient abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.

(c) Compliance with 450:70-4-11 shall be determined by:
(1) A review of facility policies and procedures,
(2) Critical incident reports at the facility, and those submitted to ODMHSAS,
(3) Performance improvement program documents and reports,
(4) Staff interviews, and
(5) Any other relevant documentation of the facility or ODMHSAS.

**450:70-4-12. Community information, consultation, outreach, and street outreach**

(a) Each ~~OSTP~~OTP shall, as a regular part of patient-based planning and services provision, provide the community with information, consultation and outreach services to aid in reaching and attracting their specified target population(s). These outreach efforts shall be conducted by staff members or approved program volunteers.

(b) These services shall be designed to:
(1) Reach and attract the facility's target population;
(2) Provide information on substance abuse and related issues to the public; and
(3) Provide information to the public regarding the facility's services.

(c) These services include, but are not limited to, presentations or outreach efforts to community groups, organizations, and individuals.

(d) Written documentation of all community information, consultation, and outreach services shall be maintained, and shall include the following:
(1) Name of person(s) or organization(s) receiving the services;
(2) Name of person(s) providing the service;
(3) Number of persons attending;
(4) Location at which the services were provided;
(5) Date services were provided; and
(6) Description of the services provided.

(e) Facilities providing street outreach services shall have written policy and procedures describing the processes for systematically reaching into a community for the purpose of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter and accept the treatment services system.

(f) Compliance with 450:70-4-12 may be determined by:
(1) A review of facility policy and procedures,
(2) Documentation of community information, consultation, and outreach services, and
(3) Any other supporting facility documentation.

## SUBCHAPTER 5. CONSUMER RIGHTS

**450:70-5-1. Consumer rights**

(a) All ~~treatment facilities~~ OTPs shall comply with applicable rules in Title 450, Chapter 15. Consumer Rights. ~~Those programs which are providing services within a correctional facility should detail the following due to circumstance:~~
~~(1) The provider shall document provisions of 450:15-3-2 (a), (b), and (d).~~
~~(2) The provider shall provide written grievance policy and procedure including time frames for the grievance process.~~
~~(3) The provider shall describe the procedure used when the grievance is against a staff. This policy may refer to DOC mandated policy and procedure.~~
~~(4) The provider shall describe the facility's responsibility for evaluation, review, and resolution should the allegation be substantiated.~~

(b) Compliance with 70-5-2 may be determined by a review of the following:
(1) Policy and Procedures,
(2) Review of treatment records, and
(3) Any other supporting facility documentation.

**450:70-5-2. Consumer's grievance policy**

(a) Each treatment facility shall comply with applicable rules in Title 450, Chapter 15. Consumer Rights.

(b) Compliance with 70-5-2 may be determined by a review of the following:
(1) Policy and Procedures,

(2) Review of treatment records, and
(3) Any other supporting facility documentation.

**450:70-5-3. ODMHSAS advocate general**

(a) The ODMHSAS Advocate General, in any investigation regarding consumer rights, shall have access to consumers, facility records and facility staff as set forth in Title 450, Chapter 15.

(b) Compliance with 70-5-3 may be determined by a review of the following:
(1) Policy and Procedures,
(2) Review of all facility records, and
(3) Investigations, site visits, treatment protocols, patient records, clinical service manuals and certification reviews.

## SUBCHAPTER 6. SUBSTANCE ABUSE TREATMENT SERVICES

## PART 1. CASE MANAGEMENT

**450:70-6-1. Case management, adults**

~~(a) Case management is an essential element during the treatment process which enhances the patient's potential for successful recovery. Case management services are designed to address areas of a patient's life that, if not addressed, often contribute to relapse. Case management services facilitate the patient's potential for a successful re-integration into community living. Case management services may be provided by either the primary service provider or a Certified Behavioral Health Case Manager.~~

~~(b) Case management services shall be made available to all patients involved with an OSTP and shall include the following:~~
~~(1) Screening to determine the priority of needs to be addressed through case management services; which shall include the completion of an assessment. and evidence that the following were evaluated:~~
~~(A) Patient's job skills and potential;~~
~~(B) Patient's strengths and resources;~~
~~(C) Patient's present living situation and support system;~~
~~(D) Patient's needs or problems which interfere with the ability to successfully function in the community;~~
~~(E) Patient's use of substances and stage of change; and~~
~~(F) Patient's medical and health status.~~
~~(2) Case management services and monitoring shall address issues and problem identified in the consumer evaluation and shall also:~~
~~(A) Incorporate needed referral sources to address the patient's identified needs;~~
~~(B) Be developed jointly between the Certified Behavioral Health Case Manager or primary service provider, and the patient; and~~
~~(C) Address the provision and frequency of case management services specified in the treatment plan.~~

~~(c) Case management referrals for adults include, but are not limited to:~~
~~(1) Medical, dental, and other health care services;~~
~~(2) Psychiatric and psychological services;~~
~~(3) Violence and domestic violence services;~~
~~(4) Family, and significant other, counseling services;~~
~~(5) Educational services, including vocational rehabilitation services;~~
~~(6) Employment services;~~
~~(7) Social services, including supplemental income, food and public housing;~~
~~(8) Legal services;~~
~~(9) Recovery self-help fellowships;~~
~~(10) Parenting and child development education; and~~
~~(11) Continuing substance abuse treatment at a lesser level of care.~~

OTPs shall comply with all applicable rules in Title 450, Chapter 50. Standards and Criteria for Certified Behavioral Health Case Managers.

**450:70-6-2. Case management services, locale and frequency [REVOKED]**

~~Case management services shall be provided within community settings; or any other appropriate settings, based on the individual needs of the patient. Contact with patients shall be made as specified in the treatment plan.~~

**450:70-6-3. Case management services, staff credentials [REVOKED]**

~~Individuals providing case management services shall be certified as a behavioral health case manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50, or be the primary service provider.~~

## PART 2. LEVELS OF TREATMENT

**450:70-6-4. Levels of Care**

(a) ~~OSTPs~~OTPs shall document the provision~~ of one (1) or more~~ of the following levels of care in policy and procedure, with the exception of medication units, unless that level of service is provided. All facilities shall include the requirements found in Facility Record System. ~~Any~~ All ~~OSTP~~OTPs certified by ODMHSAS providing any of the following levels of care shall also provide short and long term withdrawal treatment.

(b) Compliance with 70-6-4 may be determined by a review of the following:
(1) Policy and Procedures,
(2) Review of treatment records, and
(3) Any other supporting facility documentation.

**450:70-6-5. Withdrawal treatment**

(a) Any ~~OSTP~~OTP providing medication assisted treatment shall provide withdrawal treatment including both short and long term withdrawal treatment as defined in 450:70-6-7 and 450:70-6-8.

(b) The ~~OSTP~~OTP shall have written policy and procedure defining the protocols developed, implemented, and complied with for withdrawal treatment. Protocols shall:

(1) Promote successful withdrawal treatment;

(2) Require that dose reduction occur at a rate well tolerated by the patient;

(3) Require that a variety of ancillary services, such as mutual support groups, be available to the patient through the agency or through referral;

(4) Require that the amount of counseling available to the patient be increased prior to discharge; and

(5) Require that a patient be re-admitted to the agency or referred to another agency at the first indication of relapse unless it is an administrative withdrawal process.

(6) There is no minimum time in treatment requirement for patients receiving buprenorphine when granting take-home privileges.

~~(c) The OSTP shall have written policy and procedure stating patients involved in maintenance treatment will enter withdrawal treatment;~~

~~(1) Only when initiated as administrative withdrawal or when requested by the patient and approved by the OSTP medical director; and~~

~~(2) When planned and supervised by the medical director or a program physician;~~

~~(d) The OSTP shall have written policy and procedure stating that before a patient begins withdrawal treatment, the patient must be:~~

~~(1) Informed by the agency medical director, a program physician or a staff member that:~~

~~(A) The patient has the right to leave opioid treatment at any time,~~

~~(B) The risks of withdrawal treatment, and~~

~~(C) Signs and symptoms of relapse.~~

~~(2) The patient will receive a schedule for medical withdrawal treatment developed by the medical director or a program physician with input from the patient.~~

~~(e) The OSTP shall have written policy and procedure stating that if a patient who is receiving withdrawal treatment for reasons other than administrative withdrawal, appears to a staff member to relapse, the patient is permitted to reenter maintenance treatment, if otherwise eligible;~~

~~(f) The OSTP shall have written policy and procedure stating that if a patient who has completed withdrawal treatment within the past thirty (30) days appears to a staff member to relapse, the patient may be re-admitted to treatment without physical examination or assessment unless requested by the medical director.~~

~~(g) The OSTP shall have written policy and procedure stating periodic consideration shall be given to withdrawing from continued opioid treatment, when appropriate to the patient's progress and goals.~~

~~(1) Consideration for withdrawal from continued opioid treatment shall be discussed at least once annually with the patient.~~

~~(2) Such consideration and decisions shall be determined by the patient, medical director, and the program staff as part of an individualized treatment planning process and treatment progress.~~

(c) Compliance with 450:70-6-5 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records,

(3) Interviews with staff, and

(4) Other facility documentation.

**450:70-6-5.1. Withdrawal treatment - Maintenance to withdrawal treatment**

(a) The OTP shall have written policy and procedure stating patients involved in maintenance treatment will enter withdrawal treatment:

(1) Only when initiated as administrative withdrawal or when requested by the patient and approved by the OTP medical director; and

(2) When planned and supervised by the medical director or a program physician.

(b) The OTP shall have written policy and procedure stating that before a patient begins withdrawal treatment, the patient must be:

(1) Informed by the agency medical director, a program physician or a staff member that:

(A) The patient has the right to leave opioid treatment at any time,

(B) The risks of withdrawal treatment, and

(C) Signs and symptoms of relapse.

(2) The patient will receive a schedule for medical withdrawal treatment developed by the medical director or a program physician with input from the patient.

(c) Compliance with 70-6-5.1 may be determined by a review of the following:

(1) Policy and Procedures,

(2) Review of treatment records, and

(3) Any other supporting facility documentation.

**450:70-6-5.2. Withdrawal treatment - Reentering maintenance treatment**

(a) The OTP shall have written policy and procedure stating that if a patient who is receiving withdrawal treatment for reasons other than administrative withdrawal, appears to a staff member to relapse, the patient is permitted to reenter maintenance treatment, if otherwise eligible;

(b) The OTP shall have written policy and procedure stating that if a patient who has completed withdrawal treatment within the past thirty (30) days appears to a staff member to relapse, the patient may be re-admitted to treatment without physical examination or assessment unless requested by the medical director.

(c) The OTP shall ensure there shall be periodic consideration given to withdrawing from continued opioid treatment, when appropriate to the patient's progress and goals.

(1) Consideration for withdrawal from continued medication assisted opioid treatment shall be discussed at least once annually with the patient.

(2) Such consideration and decisions shall be determined by the patient, medical director, and the program staff as part of an individualized treatment planning process and treatment progress.

(d) Compliance with 70-5-2 may be determined by a review of the following:

(1) Policy and Procedures,

(2) Review of treatment records, and

(3) Any other supporting facility documentation.

**450:70-6-6. Administrative withdrawal**

(a) The ~~OSTP~~OTP shall have written policy and procedure stating an infraction of program rules by a patient may result in administrative medical withdrawal from methadone or buprenorphine and termination from treatment. All patients will be notified of this policy. The program shall develop specific program requirements to address noncompliance with program rules resulting in termination. The violation or noncompliance with rules shall be limited to;

(1) Threats of violence or actual bodily harm to staff or another patient, including abusive language or behavior;

(2) Disruptive behavior, loitering;

(3) Diversion of methadone, selling, distributing, using, or otherwise "dealing" in any illicit drug or chemical, including positive urine tests for non-prescribed medications and drugs;

(4) Continued unexcused absences from counseling and other support services;

(5) Involvement in criminal activities;

(6) Any other serious rule violations; and

(7) Non-payment of fees.

(b) The ~~OSTP~~OTP shall ensure ~~have written policy and procedure stating~~ administrative medical withdrawal shall be scheduled in such a way as to minimize the psychological and physical effects of such withdrawal.

(1) Administrative medical withdrawal shall be completed in a manner appropriate to the client's level of medication and the circumstances justifying such action;

(2) Programs may facilitate a transfer to another program or referral to a medical facility in lieu of administrative medical withdrawal; and

(3) Administrative withdrawal resulting from ~~nonpayment~~non-payment of fees cannot be accomplished in less than fifteen (15) days.

(c) The ~~OSTP~~OTP shall have written policy and procedure stating a patient experiencing administrative withdrawal shall be referred or transferred to an agency that is capable of, or more suitable for, meeting the patient's needs. The referral or transfer is documented in the patient record and the following information is documented in the patient record:

(1) The reason that the patient sought medical withdrawal or was placed on administrative withdrawal; and

(2) The information and assistance provided to the patient in withdrawal treatment, medical withdrawal or administrative withdrawal.

(d) Compliance with 450:70-6-6 may be determined by:

(1) A review of policies and procedures,

(3) Treatment records,

(4) Critical incident reports,

(5) Interviews with staff, and

(6) Other facility documentation.

**450:70-6-7. Short term withdrawal (detoxification)**

(a) The ~~OSTP~~OTP shall have written policy and procedure regarding short term withdrawal (detoxification) treatment.

(b) There shall be written policy stating a patient may be admitted to short-term withdrawal (detoxification) regardless of age. Patients under the age of eighteen (18) may be admitted with written parent or guardian approval.

(c) The program physician shall document in the patient record the reason for admitting the patient to short-term withdrawal (detoxification).

(d) Take-home medication is not allowed during short-term withdrawal (detoxification).

(e) A history of one year or more opioid dependence and an attempt at another form of treatment is not required for admission to short-term withdrawal (detoxification).

(f) No test or analysis is required except for the initial drug screening test, and a tuberculin skin test.

(g) The initial treatment plan and periodic treatment plan evaluation required for comprehensive maintenance patients are required for short-term withdrawal (detoxification) patients.

(h) A primary counselor must be assigned by the program to monitor a patient's progress toward the goal of short-term withdrawal (detoxification) and possible drug-free treatment referral.

(i) ~~The narcotic drug~~Methadone is required to be administered daily by the ~~OSTP~~OTP in reducing doses to reach a drug-free state over a period not to exceed thirty (30) days. Buprenorphine shall be administered as determined by the OTP medical director.

(j) All other requirements of comprehensive maintenance treatment apply.

(k) Compliance with 450:70-6-7 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records,

(3) Interviews with staff, and

(4) Other facility documentation.

**450:70-6-8. Long term withdrawal (detoxification)**

(a) There shall be written policy stating a patient may be admitted to long-term withdrawal detoxification regardless of age. Patients under the age of eighteen (18) with written parent or guardian approval.

(b) ~~The narcotic drug~~Methadone is required to be administered daily in reducing doses to reach a drug-free state over a period not to exceed one hundred and eighty (180) days. Buprenorphine shall be administered as determined by the OTP medical director.

(c) The patient is required to be under observation while ingesting the drug at least six (6) days a week. This is not required for buprenorphine.
(d) Initial and random monthly drug screening tests must be performed on each patient.
(e) Initial service plans and monthly ~~treatmentplans~~service plan reviews are required.
(f) All other requirements of comprehensive maintenance treatment apply.
(g) A history of ~~two~~ one year~~s~~ of opioid dependence and an attempt at another form of treatment is not required for admission to long-term withdrawal (detoxification).
(h) Compliance with 450:70-6-8 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-6-9. Interim maintenance treatment**

(a) The ~~OSTP~~OTP shall have documentation before providing interim maintenance treatment services indicating the written approval of both SAMHSA and ODMHSAS.
(b) The ~~OSTP~~OTP shall have written policy and procedure stating the program sponsor may place an individual who is eligible for admission to comprehensive maintenance treatment in interim maintenance treatment if the individual cannot be placed in comprehensive maintenance treatment within a reasonable geographic distance and within fourteen (14) days of application for admission to comprehensive maintenance treatment.
(c) The ~~OSTP~~OTP shall ~~have written policy and procedure identifying~~identify the maximum length of stay in interim opioid treatment is one hundred and twenty (120) days.
(d) The ~~OSTP~~OTP shall ~~have written policy and procedure stating~~ provide an initial and a minimum of two (2) additional drug screens shall be taken from interim patients during the one hundred and twenty (120) days of interim treatment.
(e) The ~~OSTP~~OTP shall have written policies and procedures outlining all criteria for transfer from interim maintenance to comprehensive maintenance treatment.
(f) The ~~OSTP~~OTP shall have policy and procedure ensuring interim maintenance treatment shall be provided in a manner consistent with all applicable Federal and State laws and regulations.
(g) The interim maintenance treatment program shall meet and/or possess all applicable Federal and State certifications, licensures, laws and regulations.
(h) The ~~OSTP~~OTP shall have written policy and procedure stating all rules and requirements for comprehensive maintenance treatment apply to interim maintenance treatment with the exception of:
(1) Opioid agonist treatment medication is required to be administered daily and under observation. Unsupervised or take home dosing is not allowed.
(2) A primary counselor does not need to be assigned.
(3) Interim maintenance treatment is limited to two (2) one hundred and twenty (120) day episodes in any twelve (12) month period.
(4) Educational, rehabilitative and counseling services are not required.
(5) An initial treatment plan and periodic updates are not required.
(i) Compliance with 450:70-6-9 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records,
(3) Interviews with staff, and
(4) Other facility documentation.

**450:70-6-10. Medication units, long term care facilities and hospitals**

(a) Before providing medication assisted opioid treatment services through a medication unit, long term care facility or hospital, the program must receive the written approval of both SAMHSA and ODMHSAS and certified by ODMHSAS.
(b) Certification as an ~~OSTP~~OTP will not be required for the maintenance or detoxification treatment of a patient who is admitted to a hospital or long term care facility for the treatment for medical conditions other than opioid addiction and who requires maintenance or detoxification treatment during the stay in the hospital or long term care facility.
(c) Medication units, long term care facilities and hospitals shall be in compliance with the following:
(1) Currently licensed by the ~~U. S. Drug Enforcement Agency~~ DEA; and approved by ~~the Substance Abuse and Mental Health Service Administration~~SAMHSA.
(2) Written policy and procedure stating the medical director shall make all recommendations for medication dosages according to best medical practice guidelines and all applicable rules contained in this chapter.
(3) Written policy and procedure stating all female consumers shall have a pregnancy test on admission and at least annually thereafter, unless otherwise indicated.
(4) Written policy and procedure to address the provision of all services in compliance with Federal Drug Administration Guidelines for opioid treatment programs in accordance with 42 CFR, Part 8.
(d) Compliance with 450:70-6-10 may be determined by:
(1) A review of policies and procedures,
(2) Certifications and licenses, and
(3) Other facility documentation.

**450:70-6-11. Programs using opioid antagonist or long acting opioid agonist**

(a) The ~~OSTP~~OTP shall have written policy and procedure stating a certified substance abuse facility providing a program using an experimental opioid blockade or a long acting agonist or partial agonist in the treatment of opioid substance abuse shall have documentation of approval by the Federal Drug Administration; and comply with all other federal and state statutes and regulations governing such programs.
(b) The ~~OSTP~~OTP shall have written policy and procedure stating the program shall provide at least two (2) hours of services per day before 8:00 A.M. or after 5:00 P.M. for dispensing and counseling.

~~(c) Compliance may be determined by a review of facility policy and procedures, and documentation of FDA approval.~~

(~~d~~c) The OTP shall have written policy and procedure stating that unless otherwise indicated all relevant sections of this chapter apply.

(d) Compliance with 70-6-11 may be determined by:

(1) A review of facility policy and procedures, and

(2) Documentation of FDA approval.

(3) Other facility documentation.

**450:70-6-12. HIV education, testing and counseling services**

(a) All ~~OSTPs~~OTPs shall provide and document the provision of HIV education, testing, and counseling services for drug dependent persons. Every ~~OSTP~~OTP shall:

(1) Provide educational sessions regarding HIV to such persons, and also make the sessions available to spouses or other sexual partners of the drug dependent person;

(2) Refer all drug dependent persons for HIV infection testing and counseling;

~~(3) Provide HIV testing and counseling by the facility staff, or with an organization for the testing or counseling services and maintain all test results in the confidential manner prescribed by applicable state or federal statutes or regulations; and~~

~~(4) Provide services described in items (1) through (3) at least once during each episode of treatment.~~

(b) Compliance with 450:70-6-12 may be determined by:

(1) A review of policies and procedures, and

(2) Treatment records.

(3) Other facility documentation.

**450:70-6-13. Treatment Professional [REVOKED]**

~~Only a treatment professional, as defined in 450:70-1-1, shall provide alcohol and drug treatment services in any level of care.~~

**450:70-6-14. Co-occurring Disorder Capability [REVOKED]**

~~All program components described in this chapter shall work toward becoming co-occurring disorder capable, and engage in a performance improvement process to enhance co-occurring capability, according to the State Integrated Services Initiative consensus document. Co-occurring capability involves the development of specific policies and procedures to welcome, screen and process of assessment, treatment planning, treatment programming, interagency care coordination, psychopharmacologic management, and discharge planning to ensure that attention to assisting the patient with managing his or her co-occurring mental illness is appropriately organized as a component of the substance abuse treatment intervention.~~

## PART 3. PHASES OF TREATMENT

**450:70-6-15. Treatment**

(a) Each ~~OSTP~~OTP shall use opioid agonists or partial agonists in conjunction with other treatment modalities such as, but not limited to, individual, family and group therapy; vocational training and placement; and other modalities enhancing positive life style changes in the consumer.

~~(b) The OSTP shall have written policy and procedure stating the medical director shall ensure the consumer's daily opioid dosage shall conform with all State and Federal guidelines and this chapter.~~

~~(c) The OSTP shall have written policy and procedure stating each patient accepted for treatment as a patient at an OSTP shall be assessed no less than annually by the medical director or an appropriately trained program physician as part of a process to determine the most appropriate combination of services and treatment.~~

~~(d) The OSTP shall have written policy and procedure stating the OSTP shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OSTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to all patients.~~

~~(e) Services shall be designed to provide a variety of professional diagnostic and primary alcohol and other drug abuse treatment services for consumers, and their families and significant others, whose emotional and physical status allows them to function in their usual environment.~~

~~(f) The OSTP shall have written policy and procedure stating there will be referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients who either request such services or who have been determined through the assessment process to be in need of such services.~~

~~(g) The OSTP shall have written policy and procedure stating patients accepted for opioid substitution treatment shall attend prescribed counseling as mandated in the individualized treatment plan and this chapter.~~

~~(h) The OSTP shall have written policy and procedure stating that each patient accepted for treatment at an OSTP shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment. The treatment plan also must identify the frequency and intensity of services to be provided. The plan must be reviewed and updated to reflect that patient's personal history, current needs for medical, social, and psychological services, and current needs for education, vocational rehabilitation, and employment services.~~

~~(i) The OSTP shall have written policy and procedure stating the OSTP will provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and~~

~~sociological background of patients, to contribute to the appropriate treatment plan for the patient and to monitor patient progress.~~

~~(j) The OSTP shall have written policy and procedure stating if a patient misses appointments for two weeks or more without notifying the clinic, the episode of care is considered terminated and is to be so noted in the patient's record. An exception determination would be in circumstances where the patient can provide documented proof of exceptional circumstances. The documentation must be maintained in the patient's record. If the patient does return for care and is accepted into the program, the patient is considered a new patient and is to be so noted in the patient's record.~~

(b) Compliance with 450:70-6-15 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-15.1. Treatment - Dosing**

(a) The OTP shall have written policy and procedure stating the medical director shall ensure the patient's daily medication dosage shall conform with all State and Federal guidelines, best medical practice and this chapter.

(b) Compliance with 450:70-6-15.1 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-15.2. Treatment - Medical Director visits**

(a) The OTP shall have written policy and procedure stating each patient accepted for treatment as a patient at an OTP shall be assessed no less than annually by the medical director or an appropriately trained program physician as part of a process to determine the most appropriate combination of services and treatment.

(b) Compliance with 450:70-6-15.2 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-15.3. Treatment - Clinical services**

(a) The OTP shall have written policy and procedure stating the OTP shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to all patients.

(b) Services shall be designed to provide a variety of professional diagnostic and primary medication assisted opioid treatment services for patients, and their families and significant others, whose emotional and physical status allows them to function in their usual environment.

(c) The OTP shall have written policy and procedure stating there will be referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients who either request such services or who have been determined through the assessment process to be in need of such services.

(d) The OTP shall have written policy and procedure stating patients accepted for opioid treatment shall attend prescribed counseling as mandated in the individualized service plan and this chapter.

(e) Time in treatment shall not be a requirement for patients receiving buprenorphine when granting take-home privileges.

(f) Compliance with 450:70-6-15.3 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-15.4. Treatment - Termination**

(a) The OTP shall have written policy and procedure stating if a patient misses appointments for two weeks or more without notifying the clinic, the episode of care is considered terminated and is to be so noted in the patient's record. An exception determination would be in circumstances where the patient can provide documented proof of exceptional circumstances. The documentation must be maintained in the patient's record. If the patient does return for care and is accepted into the program, the patient is considered a new patient and is to be so noted in the patient's record.

(b) Compliance with 450:70-6-15.4 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-16. ~~Women and pregnant~~Pregnant women**

(a) The ~~OSTP~~OTP shall have written policy and procedure stating the ~~OSTP~~OTP address the special needs of patients who are pregnant. Prenatal care ~~and other gender specific services or~~for pregnant patients must be provided either by the ~~OSTP~~OTP or by referral to appropriate healthcare providers.

(b) An ~~OSTP~~OTP shall ensure that policies and procedures are developed, implemented, and complied with for the treatment of ~~female~~pregnant patients, to include:

(1) Documentation that staff members are educated in the unique needs of ~~female~~pregnant patients,

~~(2) A requirement that each female patient be informed about or referred to a same sex support group at the agency or in the community, and~~

(~~3~~2) An ~~OSTP~~OTP shall ensure that ~~a~~ policy and ~~procedure is~~procedures are developed, implemented, and complied with for the treatment of pregnant patients, to include:

(A) Priority is given to pregnant individuals seeking medication assisted opioid treatment;

(B) The reasons for a pregnant individual's denial of admission to an agency are documented;

(C) A pregnant patient is offered prenatal care either at the agency or through referral to a medical practitioner;

(D) The agency shall establish a written agreement with a medical practitioner who is providing prenatal care to a pregnant patient, to include a procedure for exchanging medication assisted opioid treatment and prenatal care information;

(E) A staff member shall educate a pregnant patient who does not obtain prenatal care services for prenatal care;

(F) A staff member shall obtain a written refusal of prenatal care services from a pregnant patient who refuses prenatal care services offered by the agency or a referral for prenatal care;

(G) A pregnant patient receiving comprehensive maintenance treatment before pregnancy shall be maintained at the pre-pregnancy dose of opioid agonist or partial agonist medication, if effective;

~~(H) Dosage requirements shall be followed for a pregnant patient's initial and subsequent doses of opioid agonist treatment medication;~~

(~~I~~H) A pregnant patient shall be monitored by an agency medical practitioner to determine if pregnancy induced changes in the elimination or metabolization of opioid agonist or partial agonist treatment medication may necessitate an increased or split dose;

(~~J~~I) A pregnant patient discharged from the agency shall be referred to a medical practitioner and that a staff member document the name, address, and telephone number of the medical practitioner in the patient record; and

~~(K) While eventual withdrawal from the use of all drugs, including methadone, may be an appropriate treatment goal, some clients may remain in opioid treatment for relatively long periods of time.~~

(c) Compliance with 70-6-11 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records,

(3) Interviews with staff, and

(4) Other facility documentation.

**450:70-6-17. Treatment phases - Take home doses**

(a) The ~~OSTP~~OTP shall have written policy and procedure describing practices in accordance with the principle that take-home doses of methadone and buprenorphine are a privilege given only to those individuals who will benefit from them and who have demonstrated responsibility in taking methadone or buprenorphine as prescribed including:

(1) The requirement of time in treatment as outlined elsewhere in this rule shall be considered as a minimum reference point after which a patient may be considered for take-home privileges. ~~The time reference in this chapter does not mean that a patient in treatment for a particular time has a specific right to take-home medication.~~

(2) Programs must educate the patient regarding safe transportation and storage of methadone as well as emergency procedures in case of accidental ingestion.

(3) Before take-home privileges are allowed, the patient must have a lock box for transportation of methadone and home storage.

(4) The program shall ~~have policies that~~ address the responsibilities of patients granted take-home medications. The policies shall include methods of assuring patient's appropriate use and storage of medication.

(5) The program shall ~~have policies in place addressing~~address the disposal of take-home bottles for methadone to include;

(A) Requiring take-home bottles to be returned to the ~~OSTP~~OTP and to require labels to be intact and the consequences for not returning bottles described.

(B) Allowing patient disposal of take-home bottles to include procedures to insure the ability of the ~~OSTP~~OTP to check for diversion by requiring patients to submit used take-home bottles in "call backs".

(6) Regardless of time in treatment, the medical director, using reasonable judgment, may deny or rescind the take-home medication privileges of a patient.

(7) All take-home privileges shall be made according to the rules of this section regarding the patients' current phase of treatment.

~~(b) The OSTP shall have written policy and procedure stating the medical director may, based on reasonable judgment, grant emergency take home doses of methadone based on emergency circumstances related to medical, criminal justice, family or employment. The circumstances and basis for the action must be documented in the patient record and should address the concerns outlined in this section.~~

~~(1) Take home doses for instate emergencies is limited to a maximum of three (3) doses and out-of-state is limited to a maximum of six (6) doses.~~

~~(2) The medical director may, based on reasonable judgment, grant vacation take-home doses of methadone for up to two (2) weeks per calendar year. The circumstances and basis for the action must be documented in the patient record and should address the concerns outlined in this section.~~

~~(3) All exceptions with take-home medication must be authorized through the exception request process.~~

~~(c) The OSTP shall have written policy and procedure describing structured phases of treatment and rehabilitation to support patient progress and to establish requirements regarding patient attendance and service participation. The requirements listed below for each phase indicate minimum requirements and the frequency and extent of treatment and rehabilitation services may be increased, based on individual patient need and unless otherwise indicated in this chapter.~~

~~(1) Phase I consists of a minimum ninety (90) day period in which the patient attends the program for observation of opioid treatment daily or at least six (6) days a week. Phase I take home dosage privileges are limited to a single dose each week including take home dosages required due to regularly scheduled clinic closures. All approved holidays allow an additional take home dosage.~~

~~The patient shall ingest all other doses under appropriate supervision at the clinic.~~

~~(A) During Phase I, the patient shall participate in a minimum of our (4) sessions of counseling per month with at least one (1) session being individual counseling and/or case management.~~

~~(B) During Phase I, the treatment plan shall be reviewed and updated at least monthly.~~

~~(C) Prior to the patient moving to Phase II and/or receiving take-home medication, the patient shall demonstrate a level of stability as evidenced by absence of alcohol and other drug abuse, regularity of program attendance, absence of significant behavior problems, absence of recent criminal activities, and employment, actively seeking employment or attending school if not retired, disabled, functioning as a homemaker, or otherwise economically stable.~~

~~(D) Advancement in phase and/or increased take-home privilege shall not occur without significant compliance with all current treatment plan goals.~~

~~(E) Advancement in phase and/or increased take-home privilege shall not occur if there are consistent or consecutive positive urine drug screens.~~

~~(2) Phase II is designated for patients who have been admitted more than ninety (90) days, and who have successfully met all Phase I criteria.~~

~~(A) During Phase II, the program may issue no more than two (2) take-home doses of methadone at a time including take-home dosages required due to regular and/or holiday scheduled clinic closures. With the exception of any take-home doses, the patient shall ingest all other doses under appropriate supervision at the clinic.~~

~~(B) The patient shall participate in at least two (2) counseling sessions per month during the first ninety (90) days of Phase II, with at least one (1) of the sessions being individual counseling and/or case management.~~

~~(C) After the initial ninety (90) days in Phase II, the patient shall participate in at least one (1) session of individual counseling per month.~~

~~(D) The treatment plan shall be reviewed and updated at least once every three (3) months during Phase II.~~

~~(E) Advancement in phase and/or increased take-home privilege shall not occur without significant compliance with all current treatment plan goals.~~

~~(F) Advancement in phase and/or increased take-home privilege shall not occur if there are consistent or current positive urine drug screens.~~

~~(G) Reduction in phase and/or decreased take-home privilege shall occur if there are consistent or consecutive positive urine drug screens and/or substantial non-compliance with the individualized treatment plan.~~

~~(3) Phase III is designated for patients who have been admitted more than six (6) months and who have successfully completed Phase II criteria.~~

~~(A) During Phase III, the program may issue no more than four (4) take-home doses of methadone plus closed and holiday days.~~

~~(B) The patient shall participate in at least one (1) session of individual counseling and/or case management per month during Phase III.~~

~~(C) The treatment plan shall be reviewed and updated at least every six (6) months during Phase III or more frequently if circumstances warrant.~~

~~(D) Advancement in phase and/or increased take-home privilege shall not occur without significant compliance with all current treatment plan goals.~~

~~(E) Advancement in phase and/or increased take-home privilege shall not occur if there are consistent or current positive urine drug screens.~~

~~(F) Reduction in phase and/or decreased take-home privilege shall occur if there are consistent or consecutive positive urine drug screens and/or substantial non-compliance with the individualized treatment plan.~~

~~(4) Phase IV is designated for patients who have been admitted more than nine (9) months and who have successfully met progressive Phase III criteria.~~

~~(A) During Phase IV, the program may issue one(1) week take-home doses plus closed and holiday days.~~

~~(B) The patient shall participate in at least one (1) session of individual counseling and/or case management per month during this phase.~~

~~(C) The treatment plan shall be reviewed and updated at least every six (6) months during this phase.~~

~~(D) Advancement in phase and/or increased take-home privilege shall not occur without significant compliance with all current treatment plan goals.~~

~~(E) Advancement in phase and/or increased take-home privilege shall not occur if there are consistent or current positive urine drug screens.~~

~~(F) Reduction in phase and/or decreased take-home privilege shall occur if there are consistent or consecutive positive urine drug screens and/or substantial non-compliance with the individualized treatment plan.~~

~~(G) For patients to be eligible for Phase IV or above they must be;~~

~~(i) be employed full time,~~

~~(ii) be a full-time student (at least twelve (12) semester hours),~~

~~(iii) be retired, or~~

~~(iv) have proof of disability.~~

~~(5) Phase V is designated for patients who have been admitted for more than one (1) year.~~

~~(A) During Phase V, the program may issue two (2) weeks maximum take-home doses.~~

~~(B) The patient shall participate in at least one (1) session of individual counseling or case management per month during this phase.~~

~~(C) The treatment plan shall be reviewed and updated at least every six (6) months during this phase.~~

~~(D) Advancement in phase and/or increased take-home privilege shall not occur without significant compliance with all current treatment plan goals.~~

~~(E) Reduction in phase and/or decreased take-home privilege shall occur if there are consistent or consecutive positive urine drug screens and/or substantial non-compliance with the individualized treatment plan.~~

~~(F) Patients who meet criteria for Phase VI, and who have been admitted to treatment for a minimum of one (1) year, and who are receiving thirty (30) days of take-home doses on July 1, 2007 shall be allowed to continue to be eligible to receive thirty (30) days of take-home doses after July 1, 2007.~~

~~(i) If this patient is reduced in phase, the privilege of thirty (30) days take-home medication shall be withdrawn.~~

~~(ii) Once lost, the privilege to receive thirty (30) days of take-home medication shall not be available again.~~

~~(iii) If patient with the privilege to receive thirty (30) days of take-home medication changes clinics, it shall be the decision of the receiving clinic to either continue or ignore the continuation of the thirty (30) take-home medication privilege.~~

~~(6) Phase VI is designated for patients who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A patient may enter this phase at any time in the treatment and rehabilitation process.~~

~~(A) During Phase VI, the medical director determines take-home doses based on stability.~~

~~(B) During Phase VI, the counselor determines the frequency of counseling sessions with input from the patient. At the onset of Phase VI, the patient may require an increased level of counseling and other support services.~~

~~(C) The counselor and patient develop a continuing care plan prior to the successful completion of treatment.~~

~~(d) The OSTP shall have written policy and procedure stating these guidelines when a patient is transferring to another clinic or level of care.~~

~~(1) The admitting program shall obtain from the patient an authorization for disclosure of confidential information, for the purpose of obtaining accurate and current information concerning the patient's treatment at the former program.~~

~~(2) The medical director or program physician shall not allow the patient to attend the clinic less frequently than the most recent schedule allowed at the former program unless:~~

~~(A) Copies of the patient's records are obtained to sufficiently document the patient's satisfactory adherence to all relevant federal and state regulations for the required time in treatment; and~~

~~(B) the physician has completed an evaluation of the patient.~~

~~(3) At a minimum, staff from the admitting program shall document in the patient record and staff from the transferring program must provide the following information before the initial dose of narcotic drug is administered to a transfer patient:~~

~~(A) The last date and amount of narcotic drug administered or dispensed at the former program;~~

~~(B) The length of time in continuous treatment;~~

~~(C) The most recent record of clinic attendance;~~

~~(D) The name, address, and telephone number of the program contacted;~~

~~(E) The date and time of the contact; and~~

~~(F) The name of the program employee furnishing the information.~~

(b) Compliance with 450:70-6-17 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-17.1. Treatment phases - Take home doses, exceptions**

(a) The OTP shall have written policy and procedure stating the medical director may, based on reasonable judgment, grant emergency take-home doses of methadone based on emergency circumstances related to medical, criminal justice, family or employment. The circumstances and basis for the action must be documented in the patient record and should address the concerns outlined in this section.

(1) Take-home doses of methadone for instate emergencies is limited to a maximum of three (3) doses and out-of-state is limited to a maximum of six (6) doses.

(2) The medical director may, based on reasonable judgment, grant vacation take-home doses of methadone for up to two (2) weeks per calendar year. The circumstances and basis for the action must be documented in the patient record and should address the concerns outlined in this section.

(3) All exceptions with take-home medication must be authorized through the exception request process.

(4) All take-home dosing considerations for patients receiving buprenorphine shall be at the discretion of the medical director and consistent with best medical practice.

(b) Compliance with 450:70-6-17.1 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-17.2. Treatment phases - General**

(a) The OTP shall have written policy and procedure describing structured phases of treatment and rehabilitation to support patient progress and to establish requirements regarding patient attendance and service participation. The requirements listed below for each phase indicate minimum requirements and the frequency and extent of treatment and rehabilitation services may be increased, based on individual patient need and unless otherwise indicated in this chapter.

(1) Advancement in phase and/or increased take-home privilege shall not occur without significant compliance with all current treatment plan goals.
(2) Advancement in phase and/or increased take-home privilege shall not occur if there are consistent or consecutive positive urine drug screens.
(3) Reduction in phase and/or decreased take-home privilege shall occur if there are consistent or consecutive positive urine drug screens and/or substantial non-compliance with the individualized service plan.
(4) For patients to be eligible for Phase IV or above they must be;
(A) be employed full time,
(B) be a full time student (at least twelve (12) semester hours),
(C) be retired, or
(D) have proof of disability.
(5) Prior to the patient advancing in Phase and/or receiving take-home medication, the patient shall demonstrate a level of stability as evidenced by:
(A) Absence of alcohol and other drug abuse,
(B) Regularity of program attendance,
(C) Absence of significant behavior problems,
(D) Absence of recent criminal activities, and
(E) employment, actively seeking employment or attending school if not retired, disabled, functioning as a homemaker, or otherwise producing evidence of economic stability.
(b) Compliance with 450:70-6-17.2 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

**450:70-6-17.3. Treatment phases - Phase I**
(a) Phase I consists of a minimum ninety (90)-day period in which the patient attends the program for observation of medication assisted opioid treatment daily or at least six (6) days a week. Phase I take-home dosage privileges are limited to a single dose each week including take home dosages required due to regularly scheduled clinic closures. All approved holidays allow an additional take-home dosage. The patient shall ingest all other doses under appropriate supervision at the clinic.
(1) During Phase I, the patient shall participate in a minimum of our (4) sessions of counseling per month with at least one (1) session being individual counseling and/or case management.
(2) During Phase I, the service plan shall be reviewed and updated a minimum of once monthly.
(b) Compliance with 450:70-6-17.3 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

**450:70-6-17.4. Treatment phases - Phase II**
(a) Phase II is designated for patients who have been admitted more than ninety (90) days, and who have successfully met all Phase I criteria.
(1) During Phase II, the program may issue no more than two (2) take-home doses of methadone at a time including take-home dosages required due to regular and/or holiday scheduled clinic closures. With the exception of any take-home doses, the patient shall ingest all other doses under appropriate supervision at the clinic.
(2) The patient shall participate in at least two (2) counseling sessions per month during the first ninety (90) days of Phase II, with at least one (1) of the sessions being individual counseling and/or case management.
(3) After the initial ninety (90) days in Phase II, the patient shall participate in at least one (1) session of individual counseling per month.
(4) The service plan shall be reviewed and updated at least once every three (3) months during Phase II.
(b) Compliance with 450:70-6-17.4 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

**450:70-6-17.5. Treatment phases - Phase III**
(a) Phase III is designated for patients who have been admitted more than six (6) months and who have successfully completed Phase II criteria.
(1) During Phase III, the program may issue no more than four (4) take-home doses of methadone plus closed and holiday days.
(2) The patient shall participate in at least one (1) session of individual counseling and/or case management per month during Phase III.
(3) The service plan shall be reviewed and updated at least every six (6) months during Phase III or more frequently if circumstances warrant.
(b) Compliance with 450:70-6-17.5 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

**450:70-6-17.6. Treatment phases - Phase IV**
(a) Phase IV is designated for patients who have been admitted more than nine (9) months and who have successfully met progressive Phase III criteria.
(1) During Phase IV, the program may issue one (1) week take-home doses plus closed and holiday days.
(2) The patient shall participate in at least one (1) session of individual counseling and/or case management per month during this phase.
(3) The service plan shall be reviewed and updated at least every six (6) months during this phase.
(b) Compliance with 450:70-6-17.6 may be determined by:
(1) A review of policies and procedures,
(2) Treatment records, and
(3) Other facility documentation.

**450:70-6-17.7. Treatment phases - Phase V**
(a) Phase V is designated for patients who have been admitted for more than one (1) year.

(1) During Phase V, the program may issue two (2) weeks maximum take-home doses.

(2) The patient shall participate in at least one (1) session of individual counseling or case management per month during this phase.

(3) The service plan shall be reviewed and updated at least every six (6) months during this phase.

(b) Compliance with 450:70-6-17.7 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

**450:70-6-17.8. Treatment phases - Phase VI**

(a) Patients who meet criteria for Phase VI, and who have been admitted to treatment for a minimum of one (1) year, and who are receiving thirty (30) days of take-home doses on July 1, 2007 shall be allowed to continue to be eligible to receive thirty (30) days of take-home doses of methadone after July 1, 2007.

(1) If this patient is reduced in phase, the privilege of thirty (30) days take-home medication shall be withdrawn.

(2) Once lost, the privilege to receive thirty (30) days of take-home medication shall not be available again.

(3) If patient with the privilege to receive thirty (30) days of take-home medication changes clinics, it shall be the decision of the receiving clinic to either continue or ignore the continuation of the thirty (30) take-home medication privilege.

(b) Phase VI is designated for patients who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A patient may enter this phase at any time in the treatment and rehabilitation process.

(1) During Phase VI, the medical director determines take-home doses based on stability.

(2) During Phase VI, the counselor determines the frequency of counseling sessions with input from the patient. At the onset of Phase VI, the patient may require an increased level of counseling and other support services.

(3) The counselor and patient develop a continuing care plan prior to the successful completion of treatment.

(c) The OTP shall have written policy and procedure stating these guidelines when a patient is transferring to another clinic or level of care.

(1) The admitting program shall obtain from the patient an authorization for disclosure of confidential information, for the purpose of obtaining accurate and current information concerning the patient's treatment at the former program.

(2) The medical director or program physician shall not allow the patient to attend the clinic less frequently than the most recent schedule allowed at the former program unless:

(A) Copies of the patient's records are obtained to sufficiently document the patient's satisfactory adherence to all relevant federal and state regulations for the required time in treatment; and

(B) the physician has completed an evaluation of the patient.

(3) At a minimum, staff from the admitting program shall document in the patient record and staff from the transferring program must provide the following information before the initial dose of methadone or buprenorphine is administered to a transfer patient:

(A) The last date and amount of opioid treatment medication drug administered or dispensed at the former program;

(B) The length of time in continuous treatment;

(C) The most recent record of clinic attendance;

(D) The name, address, and telephone number of the program contacted;

(E) The date and time of the contact; and

(F) The name of the program employee furnishing the information.

(d) Compliance with 450:70-6-17.8 may be determined by:

(1) A review of policies and procedures,

(2) Treatment records, and

(3) Other facility documentation.

*[OAR Docket #13-884; filed 5-22-13]*

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## TITLE 530. OFFICE OF PERSONNEL MANAGEMENT
## CHAPTER 10. MERIT SYSTEM OF PERSONNEL ADMINISTRATION RULES

*[OAR Docket #13-947]*

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Chapter 10. Merit System of Personnel Administration Rules [AMENDED]

**AUTHORITY:**
The Director of the Office of Management and Enterprise Services: 74 O.S., §§ 840-1.6A, 840-1.15, 840-2.17, 840-2.1, 840-2.10, 840-2.15, 840-2.20, 840-2.20A, 840-2.21, 840-2.27A et seq., 840-3.1, 840-3.2, 840-3.4, 840-3.5, 840-4.3, 840-4.12, 840-4.13, 840-4.15, 840-4.17.

**DATES:**

**Comment period:**
February 15, 2013 to March 25, 2013.

**Public hearing:**
March 22 and 25, 2013

**Adoption:**
March 28, 2013

**Submitted to Governor:**
March 29, 2013

**Submitted to House:**
March 29, 2013

**Submitted to Senate:**
March 29, 2013

**Gubernatorial approval:**
May 6, 2013

**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 23, 2013.

**Final adoption:**
May 23, 2013

**Effective:**
July 1, 2013

**SUPERSEDED EMERGENCY ACTIONS:**
**Superseded Rules:**
Subchapter 9. Recruitment and Selection
Part 9. Classified Appointments
530:10-9-92 [AMENDED]
**Gubernatorial Approval:**
January 3, 2013
**Register publication:**
30 Ok Reg 351
**Docket number:**
13-132
**Superseded Rules:**
Subchapter 15. Time and Leave
Part 5. Miscellaneous Types of Leave
530:10-15-48 [AMENDED]
Subchapter 21. Employee Assistance Programs
Part 2. State Employee Debriefing and Counseling Services [NEW]
530:10-21-10 [NEW]
530:10-21-11 [NEW]
530:10-21-12 [NEW]
**Gubernatorial Approval:**
December 5, 2012
**Register publication:**
30 Ok Reg 202
**Docket number:**
12-1078
**INCORPORATIONS BY REFERENCE:**
None.
**ANALYSIS:**
Proposed amendments to Merit Rules 530:10-1-1 through 530:10-1-53; 530:10-3-22 and 26; 530:10-5-2 through 530:10-5-90; 530:10-7-6 through 530:10-7-31; 530:10-9-5 through 530:10-9-123; 530:10-11-3 through 530:10-11-76; 530:10-13-13 through 530:10-13-73; 530:10-15-43 through 530:10-15-71; 530:10-17-31 through 530:10-17-173; 530:10-21-2 are necessary to replace all references to the Office of Personnel Management with the Office of Management and Enterprise Services and/or Human Capital Management Division of the Office of Management and Enterprise Services pursuant to the provisions of HB 3053 (2012 Legislative Session) . Proposed amendments to Merit Rule 530:10-15-10 and 530:10-15-12 are necessary to correct citations referencing Oklahoma Statutes. Proposed amendments to 530:10-15-11 is necessary to clarify the accumulation limits provisions. Proposed amendments to Merit Rules 530:10-17-110 through 530:10-17-114 are being proposed to clarify the Certified Public Manager® program requirements and add the ® symbol as required by the programs national accrediting body. Proposed amendments to Merit Rules 530:10-21-10, 11 and 12 are necessary to make emergency amendments permanent and pursuant to implement the provisions of SB 1083 (2012 Legislative Session) that requires the Department of Human Services; Department of Mental Health and Substance Abuse Services; Department of Corrections; Department of Transportation; and Office of Juvenile Services to provide or contract to provide debriefing and counseling services for state employees who are affected by violent or traumatic events that occur in the workplace. Proposed amendments to 530:10-15-48 are necessary to make emergency amendments permanent and to incorporate the new 30 day notice requirement to state employees who are affected by a furlough, pursuant to HB 2724's (2012 Legislative Session) creation of a new section of law, Title 74 O.S. §840-2.20C. Proposed amendments to 530:10-9-92 are necessary to make emergency amendments permanent and to implement the new requirements of HB 1985 (2012 Legislative Session) amending the veteran hiring preference requirements in Title 74 O.S. §840-4.14.

Proposed amendments to 530:10-1-2 is necessary to provide clarification to terms utilized within the Merit Rules. Proposed amendments to 530:10-1-9 is necessary to identify consulting and guidance services provided by the Human Capital Management Division of the Office of Management and Enterprise Services. Proposed amendments to 530:10-1-65 is necessary to update the rule to be consistent with Oklahoma statutory language. Proposed amendments to 530:10-5-34 and 530:10-5-44 are necessary to clarify the rule and delete redundant language. Proposed amendments to 530:10-5-91 is necessary to provide clarification as to reallocation of positions and posting requirements. Proposed amendments. Proposed revocation of 530:10-7-1.2 is necessary as the rule is duplicative of statutory requirement. Proposed amendments to 530:10-7-3 is necessary to eliminate the requirement that agencies must request a midpoint exception from the Office of Management and Enterprise Services. Proposed amendments to 530:10-7-7 and 530:10-7-9 are necessary to clarify that pay differentials are not limited by the maximum of the pay band. Proposed amendments to 530:10-7-12 are necessary to delete language requiring agencies to request for an extension from the Office of Management and Enterprise Services regarding time for an employee to use accrued compensatory time. Proposed amendments to 530:10-9-37 is necessary to clarify the length of time between repeating a merit test. Proposed revocation of 530:10-9-94 is necessary to delete obsolete language. Proposed amendments to 530:10-9-102 is necessary to streamline the reinstatement periods. Proposed amendments to 530:10-9-111 is necessary to update the rule to be consistent with Oklahoma statutory language. Proposed amendments to 530:10-11-51 is necessary to remove language requiring appointing authorities to post promotional opportunities for supervisory positions. Proposed amendments to 530:10-11-110 is necessary to streamline the restrictions on detail to special duty. Proposed amendments to 530:10-11-120 is necessary to clarify language that appointing authorities are permitted to suspend with pay classified employees, whether permanent classified or probationary classified. Proposed amendments to 530:10-15-40 is necessary to clarify the rule and provide definitions for immediate family, household and personal disaster. Proposed amendments to 530:10-15-44 is necessary to clarify the military leave provisions by including statutory language. Proposed amendments to 530:10-15-46 are necessary to clarify compensation during court or jury services leave. Proposed amendments to 530:10-15-49 is necessary to clarify the responsibilities of the employer and the employee. Proposed amendments to 530:10-15-71 is necessary to clarify the use and accrual of administrative leave. Proposed amendments to 530:10-17-31 is necessary to clarify the rule as relates to disciplinary action. Proposed amendment to 530:10-17-74, 76, 77 and 80 are necessary to clarify the Carl Albert Internship Program and notification requirements.
**CONTACT PERSON:**
Kara I. Smith, Deputy General Counsel, Office of Management and Enterprise Services, 2101 N. Lincoln, G-80, Oklahoma City, OK 73105, (405) 521-2177.

**DUE TO EXCESSIVE LENGTH OF THESE RULES (AS DEFINED IN OAC 655:10-7-12) , THE FULL TEXT OF THESE RULES WILL NOT BE PUBLISHED. THE RULES ARE AVAILABLE FOR PUBLIC INSPECTION AT THE OFFICE OF PERSONNEL MANAGEMENT, 2101 N. LINCOLN, G-80, OKLAHOMA CITY, OK 73105, AND AT THE SECRETARY OF STATE'S OFFICE OF ADMINISTRATIVE RULES. THE FOLLOWING SUMMARY HAS BEEN PREPARED PURSUANT TO 75 O.S., SECTION 255(B) :**

**SUMMARY:**
Proposed amendments to Merit Rules 530:10-1-1 through 530:10-1-53; 530:10-3-22 and 26; 530:10-5-2 through 530:10-5-90; 530:10-7-6 through 530:10-7-31; 530:10-9-5 through 530:10-9-123; 530:10-11-3 through 530:10-11-76; 530:10-13-13 through 530:10-13-73; 530:10-15-43 through 530:10-15-71; 530:10-17-31 through 530:10-17-173; 530:10-21-2 are necessary to replace all references to the Office of Personnel Management with the Office of Management and Enterprise Services and/or Human Capital Management Division of the Office of Management and Enterprise Services pursuant to the provisions of HB 3053 (2012 Legislative Session) . Proposed amendments to Merit Rule 530:10-15-10 and 530:10-15-12 are necessary to correct citations referencing Oklahoma Statutes. Proposed amendments to 530:10-15-11 is necessary to clarify the accumulation limits provisions. Proposed amendments to Merit Rules 530:10-17-110 through 530:10-17-114 are being proposed to clarify the Certified Public Manager® program requirements and add the ® symbol as required by the programs national accrediting body. Proposed amendments to Merit Rules 530:10-21-10, 11 and 12 are necessary to make emergency amendments permanent and pursuant to implement the provisions of SB 1083 (2012 Legislative Session) that requires the Department of Human Services; Department of Mental Health and Substance Abuse Services; Department of Corrections; Department of Transportation; and Office of Juvenile Services to provide or contract to provide debriefing and counseling services for state employees who are affected by violent or traumatic events that occur in the workplace. Proposed amendments to 530:10-15-48 are necessary to make emergency amendments permanent and to incorporate the new 30 day notice requirement to state employees who are affected by a furlough, pursuant to HB 2724's (2012 Legislative Session) creation of a new section of law, Title 74 O.S. §840-2.20C. Proposed amendments to 530:10-9-92 are necessary to make emergency amendments permanent and to implement the new requirements of HB 1985 (2012 Legislative Session) amending the veteran hiring preference requirements in Title 74 O.S. §840-4.14.

Proposed amendments to 530:10-1-2 is necessary to provide clarification to terms utilized within the Merit Rules. Proposed amendments to 530:10-1-9 is necessary to identify consulting and guidance services provided by the Human Capital Management Division of the Office of Management and Enterprise Services. Proposed amendments to 530:10-1-65 is necessary to update the rule to be consistent with Oklahoma statutory language. Proposed amendments to 530:10-5-34 and 530:10-5-44 are necessary to clarify the rule and delete redundant language. Proposed amendments to 530:10-5-91 is necessary to provide clarification as to reallocation of positions and posting requirements. Proposed amendments. Proposed revocation of 530:10-7-1.2 is necessary as the rule is duplicative of statutory requirement. Proposed amendments to 530:10-7-3 is necessary to eliminate the requirement that agencies must request a midpoint exception from the Office of Management and Enterprise Services. Proposed amendments to 530:10-7-7 and 530:10-7-9 are necessary to clarify that pay differentials are not limited by the maximum of the pay band. Proposed amendments to 530:10-7-12 are necessary to delete language requiring agencies to request for an extension from the Office of Management and Enterprise Services regarding time for an employee to use accrued compensatory time. Proposed amendments to 530:10-9-37 is necessary to clarify the length of time between repeating a merit test. Proposed revocation of 530:10-9-94 is necessary to delete obsolete language. Proposed amendments to 530:10-9-102 is necessary to streamline the reinstatement periods. Proposed amendments to 530:10-9-111 is necessary to update the rule to be consistent with Oklahoma statutory language. Proposed amendments to 530:10-11-51 is necessary to remove language requiring appointing authorities to post promotional opportunities for supervisory positions. Proposed amendments to 530:10-11-110 is necessary to streamline the restrictions on detail to special duty. Proposed amendments to 530:10-11-120 is necessary to clarify language that appointing authorities are permitted to suspend with pay classified employees, whether permanent classified or probationary classified. Proposed amendments to 530:10-15-40 is necessary to clarify the rule and provide definitions for immediate family, household and personal disaster. Proposed amendments to 530:10-15-44 is necessary to clarify the military leave provisions by including statutory language. Proposed amendments to 530:10-15-46 are necessary to clarify compensation during court or jury services leave. Proposed amendments to 530:10-15-49 is necessary to clarify the responsibilities of the employer and the employee. Proposed amendments to 530:10-15-71 is necessary to clarify the use and accrual of administrative leave. Proposed amendments to 530:10-17-31 is necessary to clarify the rule as relates to disciplinary action. Proposed amendment to 530:10-17-74, 76, 77 and 80 are necessary to clarify the Carl Albert Internship Program and notification requirements.

*[OAR Docket #13-947; filed 5-29-13]*

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## TITLE 580. DEPARTMENT OF CENTRAL SERVICES
## CHAPTER 16. CENTRAL PURCHASING

*[OAR Docket #13-919]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 3. Supplier Provisions
580:16-3-21. Supplier's protest [AMENDED]
**AUTHORITY:**
74 O.S., §85.5; Office of Management and Enterprise Services.
**DATES:**
**Comment period:**
January 15, 2013 through February 15, 2013
**Public hearing:**
February 15, 2013
**Adoption:**
March 28, 2013
**Submitted to Governor:**
March 29, 2013
**Submitted to House:**
March 29, 2013
**Submitted to Senate:**
March 29, 2013
**Gubernatorial approval:**
May 6, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 23, 2013
**Final adoption:**
May 23, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
**Superseded rules:**
Subchapter 3. Supplier Provisions
580:16-3-21. Supplier's protest [AMENDED]
**Gubernatorial approval:**
August 23, 2012
**Register publication:**
30 Ok Reg 33
**Docket number:**
12-898
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
The rule establishes a time limit in which to request a stay of contract award, and clarifies existing language.
**CONTACT PERSON:**
Kimberlee Williams, Deputy General Counsel, (405) 522-3615 or kimberlee.williams@omes.ok.gov.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### 580:16-3-21. Supplier's protest

(a) A supplier may protest a contract award by a state agency or the Central Purchasing Division to the State Purchasing Director. All remedies available to suppliers through the sealed bid process pursuant to the Oklahoma Central Purchasing Act are also available to online bidders in an online bidding process.

(1) Supplier notification. A supplier shall submit written notice to the State Purchasing Director of a protest of an award of contract by a state agency or the Central Purchasing Division within ten (10) business days of contract award. The supplier protest notice shall state all facts and reasons for protest.

(2) State Purchasing Director review and determination. The State Purchasing Director shall review the supplier's protest and contract award documents.

(A) The State Purchasing Director may determine to respond to the protest or delegate the responsibility by written notice to the state agency that awarded the contract.

(B) The State Purchasing Director or state agency, whichever is applicable, shall send written notice of the decision to deny or sustain the protest to the supplier within ten (10) business days of receipt of the protest.

(3) Supplier appeal of decision to deny protest. The supplier may appeal a denial of protest
by the State Purchasing Director or a state agency to the ~~DCS~~OMES Director.

(A) ~~The~~ Such appeal shall be filed by the supplier ~~shall file a written appeal~~ within ten (10) business days of the date of the State Purchasing Director's or state agency's notice of denial pursuant to 75 O.S. §§309 et seq.

(B) The OMES Director may enter an order staying contract performance upon such terms and conditions as the OMES Director determines to be proper. Any request for stay of contract performance must be made in writing and filed during the ten (10) business day time period in which an appeal may be commenced to the OMES Director. The OMES Director shall have continuing jurisdiction to modify any such orders made in connection with a stay during the pendency of the appeal as appropriate under the circumstances presented.

(4) Director actions and determination. The ~~DCS~~OMES director may hear the appeal or assign the supplier's appeal to an Administrative Law Judge retained by the agency.

(A) If the appeal is assigned to an Administrative Law Judge, the Administrative Law Judge shall review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the Administrative Law Judge shall conduct an administrative hearing and provide proposed findings of fact and conclusions of law to the ~~DCS~~OMES Director.

(B) If the appeal is heard by the ~~DCS~~OMES Director, the ~~DCS~~OMES Director shall have all powers granted by law including all powers delegated to the Administrative Law Judge by this section.

(C) The ~~DCS~~OMES Director shall send written notice of the final order sustaining or denying the supplier's appeal to the parties.

(D) The cost of actions necessary to process a supplier's appeal, together with any other expenses incurred due to the appeal, shall be paid by the state agency responsible for the initial solicitation.

(5) Conduct of administrative hearing. Administrative hearings shall be conducted in accordance with the Administrative Procedures Act [Reference 75 O.S. §§250 et seq.] and the following procedures:

(A) Prehearing conference. A prehearing conference shall be scheduled to determine the legal or factual issues which shall be limited to those brought by the supplier in its initial protest to the State Purchasing Director.

(B) Burden of proof. The burden of proof shall be upon the supplier, which must prove its case by a preponderance of the evidence. A preponderance of the evidence is that evidence which, in light of the record as a whole, leads the Administrative Law Judge to believe a fact is more probably true than not true.

(C) Representation. Corporations must be represented by legal counsel in accordance with Oklahoma law. Legal counsel must be licensed or registered pursuant to the Rules Creating and Controlling the Oklahoma Bar Association.

(D) Proper parties. In addition to the supplier protesting the contract award, the ~~Department of Central Services~~Central Purchasing Division, the supplier awarded the contract and the state agency for which the bid was let may participate in the bid protest proceedings as a proper party.

(E) Discovery. The conduct of discovery is governed by the Administrative Procedures Act, 75 O.S. §§ 309 et seq. and other applicable law.

(F) Authority of the Administrative Law Judge. The Administrative Law Judge may:

(i) Establish a scheduling order;

(ii) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(iii) Rule on all interlocutory motions~~, including requests for a temporary stay of the contract award pending a final order from the DCS Director~~;

(iv) Require briefing of any or all issues;

(v) Conduct hearings;

(vi) Rule on the admissibility of all evidence;

(vii) Question witnesses; and

(viii) Make proposed findings of facts and conclusions of law to the ~~DCS~~OMES Director.

(G) Remedies. The Administrative Law Judge may recommend that the ~~DCS~~OMES Director deny the supplier's appeal or that the contract award be cancelled and rebid.

(6) Supplier appeal of ~~DCS~~OMES Director ~~denial~~ decision to deny appeal. If the ~~DCS~~OMES Director denies a supplier's appeal, the supplier may appeal pursuant to provisions of 75 O.S. §§ 309 et seq.

(b) An agency making an acquisition pursuant to 74 O.S. §85.5(T) shall conduct all actions and
bear all costs associated with the protest or appeal of a contract award.

*[OAR Docket #13-919; filed 5-24-13]*

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## TITLE 580. DEPARTMENT OF CENTRAL SERVICES
## CHAPTER 20. CONSTRUCTION AND PROPERTIES

*[OAR Docket #13-920]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 27. Use of Best Value Competitive Proposals to Award a Contract
580:20-27-7. Vendor selection [NEW]
**AUTHORITY:**
61 O.S. Section §103; Office of Management and Enterprise Services.
**DATES:**
**Comment period:**
January 15, 2013 through February 15, 2013

**Public hearing:**
February 15, 2013
**Adoption:**
March 28, 2013
**Submitted to Governor:**
March 29, 2013
**Submitted to House:**
March 29, 2013
**Submitted to Senate:**
March 29, 2013
**Gubernatorial approval:**
May 6, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 23, 2013
**Final adoption:**
May 23, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
**Superseded rules:**
Subchapter 27. Use of Best Value Competitive Proposals to Award a Contract
580:20-27-7. Vendor selection [NEW]
**Gubernatorial approval:**
August 23, 2012
**Register publication:**
30 Ok Reg 34
**Docket number:**
12-899
**INCORPORATIONS BY REFERENCE:**
N/A
**ANALYSIS:**
These amendments clarify requirements for testing and certification of alternative fuel technicians.
**CONTACT PERSON:**
Kimberlee Williams, Deputy General Counsel, (405) 522-3615 or kimberlee.williams@omes.ok.gov.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

**580:20-27-7. Vendor selection**

The Best Value Selection Phase uses a series of filters to identify which bidder provides the most value (lowest cost and highest performance) to the State. On or before the date stated in the solicitation, vendors submit documentation requested in the solicitation or bid documents information that will be evaluated, rated and/or weighted, and include, but are not limited to:

(1) **Past performance information.** On forms specified by the Administrator, the vendor submits performance information collected from past customers about past projects/services the vendor has completed. The selection committee does not evaluate this information and does not see the past performance scores until the selection process enters the Prioritization filter.

(2) **Project capability.** Using forms or formats specified by the Administrator, the vendor submits proof of their ability to perform the requirements of the proposed project/service specified in the solicitation, which includes but is not limited to risk assessment and mitigation, technical capability and documented performance measurements, vendor's ability to provide additional value to the State, and pricing as information required by the solicitation.

(3) **Interviews.** The Selection Monitor will schedule interviews with representatives of short-listed organization as designated by the Committee. The interview provides a forum for the vendor to discuss the project and answer questions concerning their ability to deliver the project/service to the State.

(4) **Prioritization.** After completion of (1) through (3) of this subsection by the Selection Committee, the Selection Monitor prioritizes bidders from the highest performing to least performing based upon past performance scores and the committee ratings and evaluation of the information provided by each vendor.

(5) **Dominance check.** The Selection Monitor reviews the prioritization and scoring of the bidders to identify the apparent Best Value vendor. The Selection Monitor evaluates all information to ensure that the prioritization is justifiable and there is no evidence warranting adjustment of the prioritization and ratings in any way. If the committee's ratings are not balanced, supporting past performance information is absent or pricing is not competitive or justified, the Selection Monitor may override the prioritization by providing written justification of the actions taken.

*[OAR Docket #13-920; filed 5-24-13]*

## TITLE 580. DEPARTMENT OF CENTRAL SERVICES
## CHAPTER 55. ALTERNATIVE FUELS PROGRAM

*[OAR Docket #13-921]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
580:55-1-21. Purpose [AMENDED]
580:55-1-23. Definitions [AMENDED]
Subchapter 5. Testing, Certification and Recertification
580:55-5-2. Contents of application [AMENDED]
580:55-5-10. Certificate qualification and transfer or loan of certificate [AMENDED]
Subchapter 7. Standards for Alternative Fuels Technicians - Conversion and Compression
580:55-7-4. Decals and conversion reporting procedure [AMENDED]
Subchapter 9. Violations
580:55-9-1. Alternative Fuels Technician Hearing Board; complaints, investigations, false or fraudulent representation, suspension or revocation of certificate [AMENDED]
**AUTHORITY:**
74 O.S. Section §130.18; Office of Management and Enterprise Services.
**DATES:**
**Comment period:**
January 15, 2013 through February 15, 2013
**Public hearing:**
February 15, 2013
**Adoption:**
March 29, 2013

**Submitted to Governor:**
April 1, 2013
**Submitted to House:**
April 1, 2013
**Submitted to Senate:**
April 1, 2013
**Gubernatorial approval:**
May 15, 2013
**Legislative approval:**
Failure of the Legislature to disapprove the rules resulted in approval May 24, 2013
**Final adoption:**
May 24, 2013
**Effective:**
July 1, 2013
**SUPERSEDED EMERGENCY ACTIONS:**
N/A
**INCORPORATIONS BY REFERENCE:**
**Incorporated standards:**
National Fire Protection Association, pamphlet no. 52; National Fire Protection Association, pamphlet no. 58.
**Incorporating rules:**
580:55-7-3
**Availability:**
By appointment 8:00 a.m. to 5:00 p.m. Monday through Friday except state holidays, Office of Management and Enterprise Services, Division of Capital Assets Management, Fleet Management, 317 NE 31st St., Suite A, Oklahoma City, Oklahoma, (405) 521-2206.
**ANALYSIS:**
These amendments clarify requirements for testing and certification of alternative fuel technicians.
**CONTACT PERSON:**
Kimberlee Williams, Deputy General Counsel, (405) 522-3615 or kimberlee.williams@omes.ok.gov.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

### 580:55-1-21. Purpose

The purpose of this chapter is to fulfill the mandate of Title 74 Section ~~130.14 C. 5. E.~~130.18 by establishing rules in accordance with the Alternative Fuels Technician Certification Act.

### 580:55-1-23. Definitions

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

**"Administrator"** means the Program Administrator and Recording Secretary of the Committee.

**"Agency"** means the ~~Department of Central Services~~Division of Capital Assets Management of the Office of Management and Enterprise Services.

**"Alternative fuels"** means fuels which result in comparably lower emissions of oxides of nitrogen, volatile organic compounds, carbon monoxide, or particulate matter or any combination thereof and includes CNG, LPG, LNG, methanol, ethanol, reformulated gasoline and electricity.

**"Alternative fuels compression technician"** means any person who installs, services, modifies, repairs or renovates fill stations.

**"Alternative fuels equipment technician"** means any person who installs, modifies, repairs or renovates equipment used in the conversion of any engines to engines fueled by alternative fuels and includes OEM vehicles either dedicated to operate on an alternative fuel or manufactured bi-fueled, i.e., capable of operating on gasoline or an alternative fuel.

**"Alternative Fuels Technician Certification Act"** means O.S.Title 74, Section 130.11 through 130.24.

**"Board"** means the Alternative Fuels Technician Hearing Board.

**"Capable of operating on an alternative fuel"** means any motor vehicle converted or designed to operate on an alternative fuel.

**"Charge station"** means the physical device that provides a connection from a power source to an electric vehicle as defined by the Electric Power Research Institute, and the Society of Automotive Engineers.

**"CNG"** means compressed natural gas.

**"Committee"** means the Committee of Alternative Fuels Technician Examiners.

**"Electric vehicle technician"** means any person who installs, modifies, repairs, performs maintenance on, motors, controllers, on-board power sources, or the drive systems of vehicles powered by electricity. This includes vehicles originally equipped as electric vehicles, vehicles converted from gliders, and vehicles converted from internal combustion engine vehicles.

**"Engine"** means the propulsion system of a motor vehicle. Nothing in this definition is meant to cover any stationary engine.

**"Fill station"** means the property which is directly related to the delivery of compressed natural gas, liquefied natural gas, liquefied petroleum gas otherwise known as propane, into the fuel tank of a motor vehicle propelled by such fuel including the compression equipment and storage vessels for such fuel at the point where the fuel is delivered. Compressed Natural Gas and Liquefied Petroleum Gas are subject to the NFPA code 52 and 58 respectively.

**"Glider"** means a vehicle built without an engine or fuel system for the purpose of converting it to an electric vehicle.

**"LNG"** means liquefied natural gas.

**"LPG"** means liquefied petroleum gas otherwise known as propane.

**"Motor vehicle"** means every vehicle which is self-propelled and every vehicle which is propelled by electric power obtained from overhead trolley wires, but not operated upon rails; provided, however, the definition of "motor vehicle" herein shall not include implements of husbandry.

**"NFPA"** means the National Fire Protection Association.

**"OEM"** means original equipment manufacturers.

**"Person"** means individuals, corporations, partnerships, cooperatives, associations and governmental subdivisions.

**"Work"** means any procedure involved in the physical installation or servicing of all components used in the conversion of motor vehicles to operate on alternative fuels and the

servicing of original equipment manufacturers vehicles that operate on alternative fuels, including:

(A) LPG and CNG components;

(i) tubing;

(ii) fittings;

(iii) valves;

(iv) gauges;

(v) brackets;

(vi) fuel lines;

(vii) cylinders;

(viii) tanks; and

(ix) electronic or electrical devices.

(B) Electric vehicle components;

(i) traction battery packs or modules;

(ii) motor controllers;

(iii) subsystem controllers;

(iv) inverters;

(v) drive motors;

(vi) auxiliary components powered by high voltage; and

(vii) any high voltage circuits.

"**Written**" or "**In writing**" means a tangible or electronic record of a document, communication or representation, including handwriting, typewriting, printing, photostating, photography, e-mail or other electronic format or record. A "signed" writing includes an electronic sound, symbol or process attached to or logically associated with a writing and executed or adopted by a person with the intent to sign the writing.

## SUBCHAPTER 5. TESTING, CERTIFICATION AND RECERTIFICATION

### 580:55-5-2. Contents of application.

The application shall be verified, and shall contain the following information, together with any additional information that the agency may require:

(1) Name of the applicant;

(2) Mailing Address;

(3) Address of all locations that the applicant proposes to engage in the installation or modifications of vehicles using an alternative fuel; and

(4) The type of service, set forth specifically, which the applicant intends to perform and the type of permit that the applicant seeks to secure, such as LPG, CNG, LNG, EV or other alternative fuel~~;~~.

### 580:55-5-10. Certificate qualification and transfer or loan of certificate

(a) The Agency issues a certificate as:

(1) An alternative fuels equipment technician to any person who has been certified by the Committee as either having successfully passed the appropriate examination or having a valid license or certificate issued by another governmental entity with licensing or certification requirements similar to those provided in the Alternative Fuels Technician Certification Act.

(2) An alternative fuels compression technician to any person who has been certified by the Committee as either having successfully passed the appropriate examination or having a valid license or certificate issued by another governmental entity with licensing or certification requirements similar to those provided in the Alternative Fuels Technician Certification Act.

(b) The agency shall have the authority to determine the validity of a certificate issued by another governmental entity.

(c) The agency shall assess the required certification fee and ascertain that an applicant has also complied with the provisions of the Alternative Fuels Technician Certification Act.

(d) In the case of a company, partnership or corporation engaged in the business of installing, servicing, repairing, modifying or renovating equipment used in the conversion of engines to engines fueled by alternative fuels, a separate certificate shall be issued by the agency to that individual company, partnership or corporation. The certificate is for the purpose of recognizing that the company, partnership or corporation is an authorized alternative fuels conversion business and employs state-certified alternative fuels technicians.

(e) Any violation by a certified alternative fuels equipment or compression technician shall be deemed a violation by the certified company, partnership or corporation employing such certified technician.

(f) The agency shall issue an alternative fuels equipment installation certification to any public entity or private company, partnership or corporation that operates commercial, private or public fleets of vehicles and employs ten (10) or more auto service technicians per location. The certification shall be based on the ability of the applicant to provide their own alternative fuels technician training program, which shall be certified by the committee. This certification applies only to the conversion or service of vehicles owned or operated by such public entity or private company, partnership or corporation.

(g) All alternative fuels technician equipment or compression certificates shall be non-transferable.

(h) It shall be unlawful for any person certified pursuant to the provisions of the Alternative Fuels Technician Certification Act to loan or allow the use of such certificate by any other person~~, except as specifically provided in the Alternative Fuels Technician Certification Act~~.

## SUBCHAPTER 7. STANDARDS FOR ALTERNATIVE FUELS TECHNICIANS - CONVERSION AND COMPRESSION

### 580:55-7-3. Standards for equipment ~~and fill station~~ installation and inspection

(a) The standards for the equipment installation and inspection of liquefied petroleum ~~gases~~gas vehicular fuel systems adopted by NFPA are published in the latest edition of its pamphlet No. 58.

(b) The standards for the equipment and compression installation and inspection of compressed natural gas vehicular fuel systems adopted by NFPA are published in the latest edition of its pamphlet No. 52.

~~(c) The standards for the infrastructure for the purpose of the equipment installation and inspection of compressed natural gas vehicular fuel systems adopted by NFPA are published in the latest edition of its pamphlet No. 30A.~~

## SUBCHAPTER 9. VIOLATIONS

**580:55-9-1. Alternative Fuels Technician Hearing Board; complaints, investigations, false or fraudulent representation, suspension or revocation of certificate**

(a) ~~The Agency and person~~A person or persons designated by the Agency Director or designee and the Committee shall act as the Alternative Fuels Technician Hearing Board and shall comply with the provisions of the Administrative Procedures Act.

(b) The Board may, upon its own motion, and shall, upon written complaint filed by any person, investigate the business transactions of any certified alternative fuels equipment or compression technician.

(c) The Board shall suspend or revoke any certificate or registration obtained by false or fraudulent representation.

(d) The Board shall also suspend or revoke any certificate or registration for any of the following reasons:

(1) Making a material misstatement in the application for a certificate or registration, or the renewal of a certificate or registration;

(2) Loaning or illegally using a certificate;

(3) Demonstrating incompetence to act as an alternative fuels equipment or compression technician;

(4) Violating any provisions of the Alternative Fuels Technician Certification Act, or any rule or order prescribed by the agency; or

(5) Willfully failing to perform normal business obligations without justifiable cause.

(e) The Board shall convene at the request of the committee and/or the agency director and shall have as its counsel the general counsel of the agency.

(f) The Board shall authorize the general counsel to investigate the matter or matters being considered by the Board.

(g) The General Counsel of the Agency may elect to delegate the investigation to a person or persons of his choice.

(h) Investigations are to be secret until presented to the Board for recommendations.

(i) Upon the review of the facts of the investigation, the Board may determine whether or not to hear a case.

(j) The Board and its activities shall comply with the Administrative Procedures Act.

(k) Any person whose Alternative Fuels Equipment or Compression Technician Certificate has been revoked by the Board may apply for a new certificate one (1) year from the date of such revocation.

*[OAR Docket #13-921; filed 5-24-13]*

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# TITLE 710. OKLAHOMA TAX COMMISSION
# CHAPTER 10. AD VALOREM

*[OAR Docket #13-901]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 4. Annual Valuation Mandate [REVOKED]
710:10-4-1 [REVOKED]
710:10-4-2 [REVOKED]
710:10-4-3 [REVOKED]
710:10-4-6 [REVOKED]
710:10-4-7 [REVOKED]
710:10-4-8 [REVOKED]
710:10-4-9 [REVOKED]
**AUTHORITY:**
68 O.S. § 203; Oklahoma Tax Commission
**DATES:**
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**SUPERSEDED EMERGENCY ACTIONS:**
**n/a**
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
**Subchapter 4**, "*Annual Valuation Mandate*" has been revoked to comply with the new performance audit procedures mandated by the State Board of Equalization.
**CONTACT PERSON:**
Lisa R. Haws, Tax Policy Analyst, Tax Policy and Research Division, Oklahoma Tax Commission, 2501 North Lincoln Boulevard, Oklahoma City, Ok 73194, 405-521-3133.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 4. ANNUAL VALUATION MANDATE [REVOKED]

### 710:10-4-1. Purpose [REVOKED]

~~The provisions of this Part clarify county requirements and Commission audit procedures related to annual valuation mandated by 68 O.S. § 2830(B).~~

### 710:10-4-2. Definitions [REVOKED]

~~The following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~**"Annual valuation"** means the systematic review and adjustment of the appraisals and assessments, by the county assessor, of taxable real and personal property, county-wide, on an annual basis, necessary to meet constitutional and statutory responsibilities of the ad valorem assessment process.~~

~~**"Visual inspection program"** means that program mandated by law and instituted by the counties *to gather data about real property from physical examination of the property and improvements in order to establish the fair cash values of properties so inspected at least once each four (4) years and the fair cash values of similar properties on an annual basis.* [**See:** 68 O.S. §2802(30)]~~

~~**"Actual fair cash value"** means the value or price at which a willing buyer would purchase property and a willing seller would sell property if both parties are knowledgeable about the property and its uses and if neither party is under any undue pressure to buy or sell and for real property shall mean the value for the highest and best use for which such property was actually used, or was previously classified for use, during the calendar year next preceding the applicable January 1 assessment date. [**See:** 68 O.S. §2802(18)].~~

~~**"Taxable Value"** means the percentage of fair cash value, less applicable exemptions upon which an ad valorem tax rate is levied pursuant to the provisions of Article 10, Section 8 of the Oklahoma Constitution.~~

### 710:10-4-3. Responsibilities of County Assessor [REVOKED]

~~(a) **Assessor responsible for annual valuation.** It shall be the responsibility of the county assessor to value all taxable real property and agricultural land at use value as established by the Oklahoma Constitution, Article 10 § 8, and all taxable personal property shall be valued annually as of January 1 at its actual fair cash value. The methods utilized for valuation shall be those defined by the Oklahoma Constitution, state statutes, and applicable Commission rules. Where valuation methodology is not specified by the Oklahoma Constitution, Oklahoma Statutes, State Board of Equalization guidelines, Commission rules, or bulletins, an assessor shall follow generally accepted principles of Computer Assisted Mass Appraisal as detailed in the International Association of Assessing Officers (I.A.A.O.), most recent edition, standards, books, training manuals, and similar educational courses.~~

~~(b) **Assessor responsible for all actions necessary to make, maintain, and update actual fair cash value and assessment records.** The county assessor shall carry out those activities necessary to maintain and update existing appraisal and assessment information essential for accurate annual assessments as required by law. Work activities necessary to accomplish this include review of new construction, construction of additions or modifications to existing structures, building permits (if available), demolitions, fire damage, or natural disasters such as flood, wind, rain, tornado or other causes. These work activities shall be performed utilizing approved Oklahoma Tax Commission computer generated or printed forms.~~

~~(c) **Assessor responsible for making all visual inspections required by law.** All taxable real property shall be visually inspected by the county assessor's staff on a four-year visual inspection cycle as specified in state statutes. (ref: 68 O.S. § 2820)~~

~~(d) **Assessor responsible for utilization of most current values and methodologies.** Assessors shall utilize the most current local, regional and statewide information to value all real and personal property at actual fair cash value as of January 1 each year. See: 68 O.S. § 2829. Assessors shall use the approved agricultural use value dollar per point developed for each respective county, and shall utilize the use value methodology specified in 68 O.S. § 2817(C) for valuation of agricultural land. Assessors shall periodically review agricultural land use constant with 68 O.S. § 2920 to determine if use has changed. Modifications to land use types shall be made annually if a significant change in land use has occurred, pursuant to 68 O.S. §§ 2817 and 2829.~~

### 710:10-4-6. Annual valuation of all real and personal property outside visual inspection area [REVOKED]

~~(a) **All taxable property to be valued on an annual basis.** Pursuant to 68 O.S. §§ 2829, 2817, and 2830, county assessors shall value all taxable real and personal property on an annual basis, including non-sold property outside a county's visual inspection area, for any particular tax year. Counties failing to annually value all real and personal property shall be subject to non-compliance actions as specified in 68 O.S. § 2830~~

~~(b) **Systematic county-wide review of all actual fair cash values to be conducted.** Counties shall conduct a systematic county-wide review of all market values established for ad valorem taxation on an annual basis, to adjust for changing market conditions, areas which are rapidly increasing or decreasing in value, and any other market influences affecting actual fair cash values. This shall include sales ratio studies by neighborhood or market area and county-wide. Any additions, neighborhoods, or market areas which are showing significant change through county sales ratio analysis shall be adjusted to bring those groups of properties to actual fair cash value. The IAAO Standard on Ratio Studies, latest edition, may be utilized as a guide for review parameters, in conjunction with applicable Constitutional, statutory and administrative directives.~~

~~(c) **Annual valuation of real and personal property outside of visual inspection area.** Analysis of value change impact data should be made for modified properties. Upon completion of an annual county-wide value review, an analysis of~~

~~value change impact data may be obtained by the Oklahoma Tax Commission for certain additions, neighborhoods, or market areas which have been modified.~~

**710:10-4-7. CAMA completion requirement as evidence of annual valuation [REVOKED]**

~~(a)~~ ~~**Annual valuation utilizing CAMA program required.**~~ ~~In order to be found in compliance with statutory annual valuation requirements, counties shall be required to generate and maintain actual fair cash values for all taxable property, utilizing a system of Computer Assisted Mass Appraisal (CAMA), which meets state standards, pursuant to 68 O.S. §§ 2820(C), 2829, 2830(B). Utilization of CAMA shall include an ongoing, systematic CAMA valuation program, as well as an ongoing sales verification program, with all current sales information to be entered into the respective CAMA systems for analysis and use in the valuation process.~~

~~(b)~~ ~~**Non-compliance.**~~ ~~Any county not satisfying the requirements of this section may be recommended for non-compliance to the State Board of Equalization dependent upon a detailed review of the information obtained as a part of the Annual Valuation audit contained in rules 710:10-4-8 and 710:10-4-9.~~

**710:10-4-8. Determination of compliance with annual valuation requirements; certification to the State Board of Equalization [REVOKED]**

~~Data and other information as to each component of the appraisal process shall be gathered, reviewed, and analyzed, for each county, for the previous year after any adjustments by the county assessor, county board of equalization, and county board of tax roll corrections, in order to make various compliance determinations. The non-exclusive factors listed in (1) through (11) of this Section describe the basis and methodologies which the Commission shall utilize in its compliance review of the various counties, and from which certification of annual valuation may be made to the State Board of Equalization.~~

~~(1) Review of the county's median appraisal / sales price ratio overall and by property class.~~

~~(2) Review of the county's coefficient of dispersion (COD), overall, and by property class.~~

~~(3) Review of standard statistical measures defined and described in the International Association of Assessing Officers (IAAO) most recent edition, textbooks, reference materials, and coursework or comparable.~~

~~(4) Determination of compliance, based upon review of the county's visual inspection plan and any amendments to the plan on file with the Commission.~~

~~(A) Review of the inspection area schedule contained in the current visual inspection plan on file with the Ad Valorem Division of the Commission, to determine whether adequate progress is being made.~~

~~(B) Review of area outside current year visual inspection area, to determine whether annual valuation county wide is being performed. [See: 68 O.S. § 2829(C)]~~

~~(5) Review of all property subject to value limitation, to determine compliance with Constitutional, statutory, and administrative directives.~~

~~(6) Determination of compliance, based upon a comprehensive review and comparison of previously qualified prior year sales with actual fair cash value at time of sale. Analysis will be conducted in accordance with IAAO Standards on Ratio Studies, 1999 edition. Ref: Sections 5.3 and 10.7.~~

~~(A) Median/COD comparison between the current sales and between the previous actual fair cash value.~~

~~(B) Review of the numbers, types, nature, and location of properties changed overall, for the visual inspection area, and for the remainder of the county.~~

~~(C ) Review of the date, numbers, type and nature of increases or decreases to actual fair cash value on all property.~~

~~(7) Determination of compliance, based upon a review of samples of agricultural, business, and other personal property forms, renditions and valuations.~~

~~(8) Findings upon review of personal property samples for determination of whether annual and uniform actual fair cash value is being applied on all personal property classes and types. [See: 68 O.S § 2807; 2817; 2829 and 2844.]~~

~~(9) Findings based upon review of CAMA system to determine whether the systematic generation and maintenance of values and ongoing sales file maintenance and analysis mandated by state statute is being utilized in a state approved system of computer assisted mass appraisal. [See: 68 O.S. § 2829]~~

~~(10) Findings based upon review of Oklahoma Tax Commission and State Board of Equalization approved agricultural use value methodology to determine if the county is utilizing the most current approved dollar per point and the use value methodology specified in 68 O.S. § 2817(C) for valuation of agricultural land and non residential improvements.~~

~~(11) Findings based upon review to determine if the county is monitoring agricultural land use constant with 68 O.S. § 2820 on an annual basis to determine if the actual use has changed.~~

**710:10-4-9. Findings of the annual valuation audit [REVOKED]**

~~(a) The annual valuation audit shall be based upon the factors contained in 710:10-4-8.~~

~~(b) Each county shall be given a score based upon the degree of compliance with each factor listed. The county shall be required to obtain a score of seventy percent (70%) in order to be certified as conducting annual valuation pursuant to 68 O.S. §§ 2817, 2829, and 2830(B).~~

~~(c) The Oklahoma Tax Commission will recommend to the State Board of Equalization upon review of the criteria set forth in this subsection that the county is in compliance with the~~

~~annual valuation requirement by achieving a score of seventy (70) percent.~~

~~(1) The county has complied with the State Constitutional provisions regarding assessment percentages. [**See:** Article 10, Section 8A, Okla. Const]~~

~~(2) The county's appraisal procedures are properly maintaining capped values within the five percent (5%) increase allowed unless the property is improved or transferred, and are not increasing the taxable value subject to the Constitutional Senior Valuation Limitation. [See: Article 10, Section 8C Okla. Const.]~~

~~(3) Uncapped property is valued at its actual fair cash value, based upon its highest and best use for which used, pursuant to Title 68 of the Oklahoma Statutes and Article 10, Section 8 of the Oklahoma Constitution.~~

~~(4) The county is applying the same assessment percentage for all locally valued personal property.~~

~~(5) The county is conducting its visual inspection program as described in its approved visual inspection plan.~~

~~(6) The county is conducting maintenance activity, i.e. addition of new construction and add-ons, deletions, demolition, fire/storm damage.~~

~~(7) The county is making adjustments as needed to sold and unsold property to maintain actual fair cash value countywide on an annual basis. See: OAC 710:10-4-8-6.~~

~~(8) The county is using appropriate agricultural use value methodology for land and non-residential improvements, approved by the Oklahoma Tax Commission Ad Valorem Division and State Board of Equalization for valuation of agricultural classified properties.~~

~~(9) The county is exclusively using the current Oklahoma Tax Commission approved forms for all taxpayer renditions of personal property. [See: 68 O.S. § 2835]~~

~~(10) The county is complying with all personal property classifications, annual valuation and assessment procedures. [See: 68 O.S. § 2817(A)(F); 2829; 2844(A)(B); A.G. Op. 00-23]~~

~~(d) If the county score is less than seventy percent (70%), the Oklahoma Tax Commission shall certify that the county is not in compliance with the annual valuation requirements and shall recommend to the State Board of Equalization the appropriate category of non-compliance, as required by 68 O.S. § 2830(B).~~

~~(e) The Oklahoma Tax Commission may notify the county assessor of any areas of improvements or concerns from the results of the Annual Valuation Audit. The Commission may provide the county with statistical data and other information that the Commission determines may be beneficial to the advancement of the annual valuation program.~~

*[OAR Docket #13-901; filed 5-23-13]*

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# TITLE 710. OKLAHOMA TAX COMMISSION
# CHAPTER 20. ALCOHOL, MIXED BEVERAGES AND LOW-POINT BEER

*[OAR Docket #13-902]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 2. Low-Point Beer
Part 1. General Provisions
710:20 2 5 [AMENDED]
Subchapter 3. Alcoholic Beverages
710:20-3-4 [AMENDED]
**AUTHORITY:**
Oklahoma Tax Commission; 68 O.S. § 203; 37 O.S. § 586
**DATES:**
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**SUPERSEDED EMERGENCY ACTIONS:**
**n/a**
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
Section **710:20-2-5** has been amended to conform with the provisions of Section 1 of House Bill 2576 which changed the due date for beverage tax from the 10th to the 20th day of the month for the preceding calendar month. [**37:163.5**]

Section **710:20-3-4** has been amended in accordance with the provisions of Section 2 of House Bill 2576 which modified the due date for alcoholic beverage tax from the 10th to the 20th day of the month immediately succeeding the month the alcoholic beverage tax was incurred and to reflect Commission policy regarding the due date for the reporting and remittance of alcoholic beverage tax that falls on a date that the Federal Reserve banks are closed. [**37:553**]
**CONTACT PERSON:**
Lisa R. Haws, Tax Policy Analyst, Tax Policy and Research Division, Oklahoma Tax Commission, 2501 North Lincoln Boulevard, Oklahoma City, Ok 73194, 405-521-3133.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 2. LOW-POINT BEER

## PART 1. GENERAL PROVISIONS

**710:20-2-5. Reporting requirements**

(a) **Manufacturers.** Each and every manufacturer doing business within this state must report to the Commission no later than the ~~tenth~~twentieth of each month, all sales of low-point beer made during the preceding month, including sales from any retail places of business, as described by 37 O.S. §163.7.

(b) **Wholesalers.** Each and every wholesaler doing business within this state must report to the Commission no later than the ~~tenth~~twentieth of each month, all sales of low-point beer made during the preceding month, regardless to whom the sale was made. At the same time, each and every wholesaler must report to the Commission each and every purchase or consignment of low-point beer received.

(c) **Retailers.** Each and every retailer doing business within this state must report and pay the tax to the Commission no later than the ~~tenth~~twentieth of each month, on all purchases of low-point beer made during the preceding month, on which the tax was not paid, in the same manner as a wholesaler. A retail dealer who manufactures low-point beer for consumption on the licensed premises must report and pay the tax in the same manner as a wholesaler.

(d) **Common carriers.** Monthly reports by common carriers transporting low-point beer to points within the state, are required to be furnished to the Commission. The reports will show the point of origin, the consignor, consignee, the date, and the amount of each shipment or consignment of low-point beer.

(e) **Reports must be filed electronically.** All required reports and supporting data must be filed electronically in the format prescribed by the Compliance Division.

## SUBCHAPTER 3. ALCOHOLIC BEVERAGES

**710:20-3-4. Due dates for timely filing of monthly tax reports and payment of alcoholic beverage excise tax**

(a) **Date due.** On or before the ~~tenth (10th)~~twentieth (20th) day of the calendar month immediately following the calendar month in which the alcoholic beverages, except beer, subject to tax were sold, distributed, used, possessed or in any manner dealt with in this State, the monthly alcoholic beverage tax report and payment or remittance of the tax due shall be submitted to the Oklahoma Tax Commission.

(b) **Date due not a working day.** If the due date is a Saturday, Sunday, ~~or~~ holiday recognized by the executive department of this State, or a date when the Federal Reserve Banks are closed then the due date shall be the next official working day for the Oklahoma Tax Commission immediately following such Saturday, Sunday, ~~or~~ holiday or Federal Reserve Bank closure date.

(c) **Date mailed given effect.** Any report or payment mailed and postmarked by the United States Postal Service on or prior to said due date shall be considered to have been filed or paid on the due date.

(d) **Delinquency.** All such excise tax or monthly reports due and not paid or submitted to the Commission on or before such due date shall be delinquent.

*[OAR Docket #13-902; filed 5-23-13]*

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# TITLE 710. OKLAHOMA TAX COMMISSION
# CHAPTER 22. BOATS AND MOTORS

*[OAR Docket #13-903]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 1. General Provisions
710:22-1-3 [AMENDED]
**AUTHORITY:**
Oklahoma Tax Commission; 68 O.S. § 203; 63 O.S. § 4004
**DATES:**
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**n/a**
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**
Section **710:22-1-3** has been amended to reflect the provisions of House Bill 3093, Second Regular Session of the 53rd Legislature (2012), which exempts canoes and paddleboats from the title and registration requirements of the Oklahoma Vessel and Motor Registration Act and the imposition of the vessel excise tax.
**CONTACT PERSON:**
Lisa R. Haws, Tax Policy Analyst, Tax Policy and Research Division, Oklahoma Tax Commission, 2501 North Lincoln Boulevard, Oklahoma City, Ok 73194, 405-521-3133.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

**710:22-1-3. Registration generally required**

(a) **General application.** ~~All~~With the exception of subsections (b) and (c) of this section, boats~~, unless specifically exempted,~~ used for transportation on the waters of this State and motors in excess of 10 horsepower are required to be annually registered in the State of Oklahoma.

(b) **Exclusions.** Certain craft as outlined below are not subject to the registration requirements for boats set forth in (a) of this Section:

(1) Light narrow boats with both ends sharp which are propelled by paddling such as canoes and kayaks.

(2) Paddleboats less than eight (8) feet in length designed to be propelled solely by human power through a belt, chain or gears.

(3) Seaplanes on the water.

(c) **Exemptions.** The following boats and/or motors are specifically exempted from the registration requirements of the Oklahoma Vessel and Motor Registration Act.

(1) Boats or motors owned by the United States, a state other than the State of Oklahoma, any agency thereof, or any subdivision of the state unless the boat is used for recreational or rental purposes on Oklahoma waters.

(2) Boats or motors owned by visiting nonresidents which are currently registered in another state and remain in Oklahoma sixty calendar days or less.

(3) Boats or motors from a country other than the United States which remains in Oklahoma sixty calendar days or less.

(4) Boats used exclusively and solely as lifeboats.

(5) Boats used exclusively and solely for racing purposes.

(6) Boats that constitute commercial floatation devices when issued a permit by the Oklahoma Scenic River Commission pursuant to the provision of Section 1461 et seq. of Title 82 of the Oklahoma Statutes.

*[OAR Docket #13-903; filed 5-23-13]*

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## TITLE 710. OKLAHOMA TAX COMMISSION
## CHAPTER 70. TOBACCO, TOBACCO PRODUCTS, AND CIGARETTES

*[OAR Docket #13-904]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 2. Cigarette Stamp Tax
Part 3. Delivery Sales
710:70-2-50 [AMENDED]
Subchapter 5. Excise on Tobacco Products
710:70-5-2 [AMENDED]
710:70-5-3 [AMENDED]
710:70-5-5 [AMENDED]
710:70-5-8 [AMENDED]
710:70-5-10 [REVOKED]
**AUTHORITY:**
Oklahoma Tax Commission; 68 O.S. §§ 203 and 403.1
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**n/a**
**INCORPORATIONS BY REFERENCE:**
n/a
**ANALYSIS:**

Section **710:70-2-50** has been amended to reflect the provisions of Section 6 of House Bill 2576 which changes the due date for cigarette tax reports required of licensed cigarette wholesalers from the 10th to the 20th day of the month for the previous calendar month. [**68:317.5**]

Sections **710:70-5-2** and **710:70-5-3** have been amended to outline the statutory reporting and excise tax payment requirements for tobacco retailers who receive tobacco products upon which tax has not been paid.

Section **710:70-5-5** has been amended to reflect Commission policy regarding the due date for the reporting and remittance of tobacco products tax that falls on a date that the Federal Reserve banks are closed.

Section **710:70-5-8** has been amended to conform to the statutory amendments made pursuant to Section 7 of House Bill 2576 which changed the due date for the report required of wholesalers of tobacco products pursuant to Section 413 of Title 68 from the 15th to the 20th of the month. [**68:413**]

Section **710:70-5-10** has been revoked as superfluous.

**CONTACT PERSON:**
Lisa R. Haws, Tax Policy Analyst, Tax Policy and Research Division, Oklahoma Tax Commission, 2501 North Lincoln Boulevard, Oklahoma City, Ok 73194, 405-521-3133.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 2. CIGARETTE STAMP TAX

## PART 3. DELIVERY SALES

**710:70-2-50. Filing requirements for persons making "delivery sales of cigarettes"**

(a) **General.** Before delivering any cigarettes to purchasers, every person making delivery sales into Oklahoma, or mailing, shipping, or otherwise delivering cigarettes in connection with any such sales, must provide to the Oklahoma Tax Commission a written statement containing the following information:

(1) The name of the seller;

(2) The trade name of the seller;

(3) The address of the principal place of business of the seller; and,

(4) The address of any other place of business of the seller. [68 O.S. § 317.5(A)]

(b) **Monthly report of delivery sales required.** No later than the ~~tenth~~twentieth day of each calendar month, each person who has made a delivery sale, or mailed, shipped, or otherwise delivered cigarettes in connection with any such sale during the previous month, must make a memorandum report to the Oklahoma Tax Commission of the following information:

(1) The name of the purchaser;

(2) The brands of cigarettes sold; and,

(3) The quantity of cigarettes sold. [68 O.S. § 317.5(B)]

(c) **Alternative method of compliance with reporting requirement.** Any person who satisfies the requirements set out in 15 U.S.C. 376 shall be deemed to have met the reporting requirements set out in (b) of this Section. [68 O.S. § 317.5(C)]

(d) **Reports must be filed electronically.** All required reports must be filed electronically in the format prescribed by the Compliance Division.

## SUBCHAPTER 5. EXCISE ON TOBACCO PRODUCTS

### 710:70-5-2. Payment of tax on tobacco products

The excise tax levied upon the sale, use, distribution, exchange, barter or possession of tobacco products in this State shall be paid on a monthly basis by the licensed manufacturer, wholesaler~~,~~or retailer first possessing, selling, using, distributing, exchanging, bartering, or in any manner dealing with such tobacco products in this State. No other person ~~or wholesaler~~, shall first possess, use, sell, exchange, distribute, barter or in any manner deal with such tobacco products in this State upon which the excise tax has not been paid.

### 710:70-5-3. Minimum requirements of monthly tobacco products tax reports of licensed manufacturers~~,or~~ wholesalers or retailers.

(a) Every licensed manufacturer and every wholesaler licensed by the Oklahoma Tax Commission, to possess, use or in any manner deal with tobacco products subject to the excise tax, upon which such tax has not been paid, and every retailer who receives tobacco products upon which excise tax has not been paid shall report, to the Oklahoma Tax Commission, all purchases and invoices of all such tobacco products and merchandise subject to such excise tax monthly, on the Monthly Tobacco Products Tax Report form prescribed by the Commission. Each monthly report shall include the following information:

(1) Name, business address and Tobacco License Number of the tax reporter;

(2) All purchases or deliveries, stated separately according to the dates of delivery in the State, of all tobacco products received, possessed, used or in any manner dealt with in the previous calendar month;

(3) Invoice numbers of all purchases or deliveries of such products for the previous calendar month;

(4) Name and business address of each consignee and consignor; and

(5) Copy of each invoice of all purchases or deliveries of such products for the previous month attached to the monthly report form. Copies of invoices submitted shall be subject to destruction upon completion of an office audit of the monthly report and shall not discharge the reporter from the statutory duty to maintain records and files of all such transactions. [**See:** 68 O.S. §201; 68 O.S. §401 et seq.]

(b) Monthly reports due after October 31, 2011, must be filed electronically in the format prescribed by the Commission.

(c) Copies of each invoice for sales of tobacco products made during the previous calendar month shall be attached to the monthly report form. If the number of invoices is voluminous, reporter may request and obtain authorization to submit a schedule of sales in lieu of copies of invoices.

### 710:70-5-5. Due dates for timely filing of monthly tobacco products tax reports and paying tax

(a) On or before the twentieth (20th) day of the calendar month immediately following the calendar month in which the tobacco products subject to taxation were first received, delivered, possessed, used or in any manner dealt with in this State, the Monthly Tobacco Products Tax Reports and payment of the tax due shall be submitted to the Oklahoma Tax Commission. If such due date is a Saturday, Sunday~~,or a~~ holiday recognized by the executive department of this State, or a date when the Federal Reserve Banks are closed then the due date shall be the next official working day for the Oklahoma Tax Commission immediately following the Saturday, Sunday~~,or~~ holiday or Federal Reserve Bank closure date.

(b) Any report or payment mailed and postmarked by the United States Postal Service on or prior to the due date shall be considered to have been filed or paid on the due date.

(c) All excise tax or monthly reports due and not paid or submitted to the Commission on or before the due date shall be delinquent.

### 710:70-5-8. Reports on tobacco products by persons, retailers, consumers, carriers or bailees other than those required to report and pay tax

(a) Every person or entity, listed below, who possesses, controls, transports, uses or in any manner deals with tobacco products within this State subject to the tobacco products excise tax, upon which the tax has not been paid, even though not the party required to pay the tax, shall file a monthly report to the Oklahoma Tax Commission on prescribed forms as follows:

(1) Every retailer or consumer purchasing tobacco products subject to tax in drop shipments shall report those purchases to the Oklahoma Tax Commission on the Monthly Tobacco Products Tax Reports in accordance with 710:70-5-3 through 710:70-5-5, as required of licensed manufacturers, wholesalers, retailers or consumers.

(2) Every carrier transporting tobacco products, subject to tax, to a point within this State shall monthly report to the Oklahoma Tax Commission the following information:

(A) Name and business address of the carrier;

(B) The date of delivery of each shipment of said tobacco products transported and delivered into this State in the previous calendar month;

(C) The point of origin and the point of delivery of each shipment of said tobacco products transported and delivered into this State in the previous calendar month;

(D) The name of the person or entity to whom said tobacco products were delivered in this State in the previous calendar month; and

(E) Copies of all invoices, bills of lading or instruments of consignment of said tobacco products transported and delivered into this State in the previous calendar month, attached to said report.

(3) Every bailee having possession, custody, control, use or in any manner dealing with tobacco products within this State subject to the tax, shall report monthly to the Oklahoma Tax Commission as is required of carriers.

(b) All required monthly reports shall be due on or before the ~~fifteenth (15th)~~twentieth (20th) day of the calendar month immediately following the calendar month in which the tobacco products subject to the tax are possessed, controlled, transported, used or in any manner dealt with in this State, in accordance with 710:70-5-5.

(c) Copies of invoices, bills of lading or other instruments of consignment submitted shall be subject to destruction upon completion of an office audit of the monthly report and shall not discharge the reporter from the statutory duty to maintain records and files of all such transactions and to permit inspection and examination thereof by the Commission. [**See:** 68 O.S. § 201; 68 O.S. §§ 401 et seq.]

**710:70-5-10. Prohibition against the possession, sale, use, distribution, exchange, barter, giving away or in any manner dealing with tobacco products upon which the tobacco products tax has not been paid [REVOKED]**

~~No person, dealer, distributing agent or wholesaler shall possess, sell, use, exchange, barter, give away or in any manner deal with any tobacco products within this State upon which the tax is levied and unpaid, unless the person, dealer, distributing agent or wholesaler holds a valid Tobacco License issued pursuant to statute. [**See:** 68 O.S. §§401, 415]~~

~~(1) Any person who obtains possession, custody or control of such tobacco products in this State from another other than a holder of a Tobacco License issued by the Oklahoma Tax Commission shall be subject to seizure proceedings. [**See:** 68 O.S. §417]~~

~~(2) Any person required to report or report and pay tobacco products tax, and who is delinquent in said reporting or payment shall be subject to seizure proceedings. [**See:** 68 O.S. §417; 710:70-5-11]~~

*[OAR Docket #13-904; filed 5-23-13]*

## TITLE 715. TEACHERS' RETIREMENT SYSTEM
## CHAPTER 10. GENERAL OPERATIONS

*[OAR Docket #13-915]*

**RULEMAKING ACTION:**
PERMANENT final adoption
**RULES:**
Subchapter 5. Establishing Other Service Credits
715:10-5-36 [NEW]
Subchapter 15. Service Retirement
715:10-15-3 [AMENDED]
715:10-15-6 [AMENDED]
715:10-15-26 [AMENDED]
Subchapter 17. Post-Retirement Employment
715:10-17-6 [AMENDED]
Subchapter 23. State and Education Employees Group Health and Dental Insurance Program
715:10-23-6 [NEW]
**AUTHORITY:**
70 O.S. Section 17-101, et seq., especially Section 17-106(10); Board of Trustees
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Subchapter 17. Post-Retirement Employment
715:10-17-6 [AMENDED]
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30 Ok Reg 73
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**INCORPORATIONS BY REFERENCE:**
n/a

**ANALYSIS:**

715:10-5-36 is being added to comply with the Post-EGTRRA Amendments specific to the Heroes Earnings Assistance and Tax Relief Act of 2008.

715:10-15-3 is being amended to ensure payments for additional service credit are paid timely and are accurately included in estimate of benefits and to remove restriction on how early a client may submit a retirement contract.

715:10-15-6 is being amended to update acceptable forms for verification of date of birth.

715:10-15-26 is being amended to update the Internal Revenue Code Section 415 provisions for the Worker, Retiree, and Employee Recovery Act of 2008.

715:10-17-6 is being amended to make the previously approved emergency rule permanent.

715:10-23-6 is being added to ensure compliance of OTRS plan with Internal Revenue Service (IRS) requirements to remain a qualified plan.

**CONTACT PERSON:**

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

## SUBCHAPTER 5. ESTABLISHING OTHER SERVICE CREDITS

### 715:10-5-36. Compliance with Code Section 401(a)(37) and the HEART Act

(a) Effective with respect to deaths occurring on or after January 1, 2007, while a member is performing qualified military service (as defined in chapter 43 of title 38, United State Code), to the extent required by Internal Revenue Code Section 401(a)(37), survivors of a member in a State or local retirement or pension system, are entitled to any additional benefits that the system would provide if the member had resumed employment and then died, such as accelerated vesting or survivor benefits that are contingent on the member's death while employed.

(b) Beginning January 1, 2009, to the extent required by Internal Revenue Code Sections 3401(h) and 414(u)(12), an individual receiving differential wage payments (while the individual is performing qualified military service (as defined in chapter 43 of title 38, United State Code)) from an employer shall be treated as employed by that employer and the differential wage payment shall be treated as earned compensation, but contributions attributable to such differential wage payments shall not be made unless and until the member returns to active employment and makes up the missed contributions. This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.

## SUBCHAPTER 15. SERVICE RETIREMENT

### 715:10-15-3. Date of retirement; making application

The earliest effective date of retirement for any eligible member is the first day of the month following the one in which employment ceases, with the first annuity payment due the last day of that month.

(1) It is the member's responsibility to notify, by filing a retirement contract as outlined in paragraphs 4 and 5 of this section, the TRS Board of Trustees of the date on which retirement is to begin.

(2) Payments for all years of service, for which a member wants to receive credit, must be made ~~before~~no less than 90 days prior to the date of retirement.

(3) State law does not permit TRS to make retroactive retirement payments. Members should ensure that their creditable service record is up-to-date and accurate before they retire.

(4) The member ~~shall request~~will receive a final contract for retirement ~~by~~upon completing and returning to TRS ~~Form 40 (Retirement Allowance Estimate)~~an Intent to Retire. This form should be returned to TRS ~~approximately~~no less than sixty (60) ~~to ninety (90)~~ days prior to the expected retirement date. The member shall select the retirement option on ~~TRS Form 40~~the Intent to Retire.

(5) The Final Contract for Retirement, properly executed before a notary, is required by statutes to be filed with TRS no less than thirty (30) days~~, nor more than ninety (90) days,~~ before the date of retirement. Therefore, the final contract for retirement must be completed and on file with TRS by the first day of the month immediately preceding the retirement date. The first retirement ~~check~~benefit payment will be ~~mailed~~made on the ~~last~~first day of the month following the effective date of retirement ~~begins~~.

(6) For example, a retirement contract must be on file by May 1, for a retirement date of June 1, in order ~~for the first check to be mailed the last working day of June.~~to process the first retirement benefit payment on July 1.

### 715:10-15-6. Verification of date of birth

~~A member, filing for retirement benefits, must provide proof of date of birth. Proof of the birth date of the designated beneficiary is also required when the member selects either Retirement Option 2 or Option 3. Although a birth certificate is the best evidence of correct age, one is not always obtainable. In such cases, the~~ The Board of Trustees has ruled that any of the documents listed below ~~also~~ shall be acceptable for verification of date of birth:

(1) ~~United States Census record.~~ Birth Certificate

(2) ~~Military record.~~ Valid state or federal government issued photo identification

~~(3) Naturalization record.~~

(~~4~~3) Passport ~~(must be at least five years old).~~

### 715:10-15-26. Code Section 415 limits as applied to TRS

(a) Notwithstanding any other provision of the administrative code, contributions paid to and benefits paid from the retirement system shall not exceed the maximum contributions and benefits permissible under Internal Revenue Code Section 415. For 415 testing purposes, the limitation year is the calendar year.

(b) Participation in Other Qualified Plans: Aggregation of Limits

(1) The 415(b) limit with respect to any member who at any time has been a member in any other defined benefit plan as defined in Internal Revenue Code Section 414(j) maintained by the member's employer in the retirement system shall apply as if the total benefits payable under all such defined benefit plans in which the member has been a member were payable from one (1) plan.

(2) The 415(c) limit with respect to any member who at any time has been a member in any other defined contribution plan as defined in Internal Revenue Code Section 414(i) maintained by the member's employer in the retirement system shall apply as if the total annual additions under all such defined contribution plans in which the member has been a member were payable from one (1) plan.

(c) Basic 415(b) Limitation

(1) Before January 1, 1995, a member may not receive an annual benefit that exceeds the limits specified in Internal Revenue Code Section 415(b), subject to the applicable adjustments in that section. On and after January 1, 1995, a member may not receive an annual benefit that exceeds the dollar amount specified in Internal Revenue Code Section 415(b)(1)(A), subject to the applicable adjustments in Internal Revenue Code Section 415(b) and subject to any additional limits that may be specified in the retirement system. In no event shall a member's benefit payable under the retirement system in any limitation year be greater than the limit applicable at the annuity starting date, as increased in subsequent years pursuant to Internal Revenue Code Section 415(d) and the regulations thereunder.

(2) For purposes of Internal Revenue Code Section 415(b), the "annual benefit" means a benefit payable annually in the form of a straight life annuity (with no ancillary benefits) without regard to the benefit attributable to after-tax employee contributions (except pursuant to Internal Revenue Code Section 415(n)) and to rollover contributions (as defined in Internal Revenue Code Section 415(b)(2)(A)). The "benefit attributable" shall be determined in accordance with Treasury Regulations.

(d) Adjustments to Basic 415(b) Limitation for Form of Benefit. If the benefit under the retirement system is other than the form specified in subsection (c)(2), then the benefit shall be adjusted so that it is the equivalent of the annual benefit, using factors prescribed in Treasury Regulations.

(1) If the form of benefit without regard to any automatic benefit increase feature is not a straight life annuity or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Internal Revenue Code Section 415(b) limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent amount [determined using the assumptions specified in Treasury Regulation section 1.415(b)-1(c)(2)(ii)] that takes into account the additional benefits under the form of benefit as follows:

(2) For a benefit paid in a form to which Internal Revenue Code Section 417(e)(3) does not apply [a monthly benefit], the actuarially equivalent straight life annuity benefit that is the greater of (or the reduced Limit applicable at the annuity starting date which is the "lesser of" when adjusted in accordance with the following assumptions):

(A) The annual amount of the straight life annuity (if any) payable to the member under the retirement system commencing at the same annuity starting date as the form of benefit to the member, or

(B) The annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the form of benefit payable to the member, computed using a 5% interest assumption (or the applicable statutory interest assumption) and (i) for years prior to January 1, 2009, the applicable mortality tables described in Treasury Regulation section 1.417(e)-1(d)(2) (Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Rulings 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Internal Revenue Code Section 417(e)(3)(B) (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Internal Revenue Code Section 417(e)(3)(B)); or

(3) For a benefit paid in a form to which Internal Revenue Code Section 417(e)(3) applies [a lump sum benefit], the actuarially equivalent straight life annuity benefit that is the greatest of (or the reduced Internal Revenue Code Section 415(b) limit applicable at the annuity starting date which is the "least of" when adjusted in accordance with the following assumptions:

(A) The annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using the interest rate and mortality table, or tabular factor, specified in the plan for actuarial experience;

(B) The annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using a 5.5 percent interest assumption (or the applicable statutory interest assumption) and (i) for years prior to January 1, 2009, the applicable mortality table for the distribution under Treasury Regulation section 1.417(e)-1(d)(2) (the mortality table specified in Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Ruling 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Internal Revenue Code Section 417(e)(3)(B) (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Internal Revenue Code Section 417(e)(3)(B)); or

(C) The annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable (computed using the applicable interest rate for the distribution under Treasury Regulation section 1.417(e)-1(d)(3) (the 30-year Treasury rate (prior to January 1 2007, using the rate in effect for the month prior to retirement, and on and after January 1, 2007, using the rate the in effect for the first day of the plan year with a one-year stabilization period)) and (i) for years prior to January 1, 2009, the applicable mortality rate for the distribution under Treasury Regulation section 1.417(e)-1(d)(2) (the mortality table specified in Revenue Ruling 2001-62 or any subsequent Revenue Ruling modifying the applicable provisions of Revenue Ruling 2001-62), and (ii) for years after December 31, 2008, the applicable mortality tables described in Internal Revenue Code Section 417(e)(3)(B) (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing Internal Revenue Code Section 417(e)(3)(B)), divided by 1.05.

(e) Benefits Not Taken into Account for 415(b) Limitation. For purposes of this section, the following benefits shall not be taken into account in applying these limits:

(1) Any ancillary benefit which is not directly related to retirement income benefits;

(2) That portion of any joint and survivor annuity that constitutes a qualified joint and survivor annuity;

(3) Any other benefit not required under Internal Revenue Code Section 415(b)(2) and Treasury Regulations thereunder to be taken into account for purposes of the limitation of Internal Revenue Code Section 415(b)(1).

(f) Other Adjustments in 415(b) Limitation.

(1) In the event the member's retirement benefits become payable before age sixty-two (62), the limit prescribed by this section shall be reduced in accordance with Treasury Regulations pursuant to the provisions of Internal Revenue Code Section 415(b), so that such limit (as so reduced) equals an annual straight life benefit (when such retirement income benefit begins) which is equivalent to a one hundred sixty thousand dollar ($160,000) (as adjusted) annual benefit beginning at age sixty-two (62).

(2) The reductions provided for in (1) above shall not be applicable to pre-retirement disability benefits or pre-retirement death benefits.

(g) Less than Ten (10) Years of ~~Service Adjustment for 415(b) Limitations~~Participation. The maximum retirement benefits payable under OAC 715:10-15-26 to any member who has completed less than ten (10) years of ~~service~~participation shall be the amount determined under ~~subsection (c)~~OAC 715:10-15-26(c), as adjusted under OAC 715:10-15-26(d) and/or OAC 715:10-15-26(f), multiplied by a fraction, the numerator of which is the number of the member's years of ~~service~~participation and the denominator of which is ten (10). The reduction provided by ~~this subsection~~OAC 715:10-15-26(g) cannot reduce the maximum benefit below 10% of the limit determined without regard to OAC 715:10-15-26(g). The reduction provided for in ~~this subsection~~OAC 715:10-15-26(g) shall not be applicable to pre-retirement disability benefits or pre-retirement death benefits.

(h) Ten Thousand Dollar ($10,000) Limit; Less than Ten (10) Years of Service. Notwithstanding ~~the foregoing,~~anything in OAC 715:10-15-26 to the contrary, the retirement benefit payable with respect to a member shall be deemed not to exceed the ~~415~~ limit set forth in OAC 715:10-15-26(h) if the benefits payable, with respect to such member under the retirement system and under all other qualified defined benefit pension plans to which the member's employer contributes, do not exceed ten thousand dollars ($10,000) for the applicable limitation year and for any prior limitation year and the employer has not at any time maintained a qualified defined contribution plan in which the member participated; provided, however, that if the member has completed less than ten (10) years of service with the employer in the retirement system, the limit under OAC 715:10-15-26(h) shall be a reduced limit equal to ten thousand dollars ($10,000) multiplied by a fraction, the numerator of which is the number of the member's years of service and the denominator of which is ten (10).

(i) Effect of COLA without a Lump Sum Component on 415(b) Testing.Effective on and after January 1, 2009, for purposes of applying the limits under Internal Revenue Code Section 415(b) (the "Limit") to a member with no lump sum benefit, the following will apply:

(1) a member's applicable Limit will be applied to the member's annual benefit in the member's first limitation year without regard to any cost of living adjustments under Oklahoma statutes;

(2) to the extent that the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost of living increases until such time as the benefit plus the accumulated increases are less than the Limit; and

(3) thereafter, in any subsequent limitation year, a member's annual benefit, including any cost of living increases under Oklahoma statutes, shall be tested under the then applicable benefit Limit including any adjustment to the Internal Revenue Code Section 415(b)(1)(A) dollar limit under Internal Revenue Code Section 415(d), and the regulations thereunder.

(j) Effect of COLA with a Lump Sum Component on 415(b) Testing.On and after January 1, 2009, with respect to a member who receives a portion of the member's annual benefit in a lump sum, a member's applicable Limit will be applied taking into consideration cost of living increases as required by Internal Revenue Code Section 415(b) and applicable Treasury Regulations.

(k) Section 415(c) limitations on contributions and other additions.After-tax member contributions or other annual additions with respect to a member may not exceed the lesser of $40,000 (as adjusted pursuant to Internal Revenue Code Section 415(d)) or 100% of the member's compensation.

(1) Annual additions are defined to mean the sum (for any year) of employer contributions to a defined contribution plan, member contributions, and forfeitures credited to a member's individual account. Member contributions

are determined without regard to rollover contributions and to picked-up employee contributions that are paid to a defined benefit plan.

(2) For purposes of applying Internal Revenue Code Section 415(c) and for no other purpose, the definition of compensation where applicable will be compensation actually paid or made available during a limitation year, except as noted below and as permitted by Treasury Regulation section 1.415(c)-2, or successor regulation; provided, however, that member contributions picked up under Internal Revenue Code Section 414(h) shall not be treated as compensation.

(3) Solely for purposes of calculating and complying with the limitations under Internal Revenue Code Section 415, a member's compensation will be defined as wages within the meaning of Internal Revenue Code Section 3401(a) and all other payments of compensation to an employee by an employer for which the employer is required to furnish the employee a written statement under Internal Revenue Code Sections 6041(d), 6051(a)(3) and 6052 and will be determined without regard to any rules under Internal Revenue Code Section 3401(a) that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Internal Revenue Code Section 3401(a)(2)).

(A) However, for limitation years beginning after December 31, 1997, compensation will also include amounts that would otherwise be included in compensation but for an election under Internal Revenue Code Sections 125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b). For limitation years beginning after December 31, 2000, compensation shall also include any elective amounts that are not includible in the gross income of the member by reason of Internal Revenue Code Section 132(f)(4).

(B) For limitation years beginning on and after January 1, 2009, compensation for the limitation year shall also include compensation paid by the later of 22 months after a member's severance from employment or the end of the limitation year that includes the date of the member's severance from employment if:

(i) the payment is regular compensation for services during the member's regular working hours, or compensation for services outside the member's regular working hours (such as overtime or shift differential), commissions, bonuses or other similar payments, and, absent a severance from employment, the payments would have been paid to the member while the member continued in employment with the employer; or

(ii) the payment is for unused accrued bona fide sick, vacation or other leave that the member would have been able to use if employment had continued.

(iii) payments pursuant to a nonqualified unfunded deferred compensation plan, but only if the payments would have been paid to the member at the same time if the member had continued employment with the employer and only to the extent that the payment is includible in the member's gross income.

(iv ) Any payments not described in paragraph (B) above are not considered compensation if paid after severance from employment, even if they are paid within 2 2 months following severance from employment, except for payments to the individual who does not currently perform services for the employer by reason of qualified military service (within the meaning of Internal Revenue Code Section 414(u)(1)) to the extent these payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the employer rather than entering qualified military service.

(v) An employee who is in qualified military service (within the meaning of Internal Revenue Code Section 414(u)(1)) shall be treated as receiving compensation from the employer during such period of qualified military service equal to (i) the compensation the employee would have received during such period if the employee were not in qualified military service, determined based on the rate of pay the employee would have received from the employer but for the absence during the period of qualified military service, or (ii) if the compensation the employee would have received during such period was not reasonably certain, the employee's average compensation from the employer during the twelve month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

(C) Back pay, within the meaning of Treasury Regulation section 1.415(c)-2(g)(8), shall be treated as compensation for the limitation year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included under this definition.

(4) For limitation years beginning on or after January 1, 2009, a member's compensation for purposes of subsection (k) shall not exceed the annual limit under Internal Revenue Code Section 401(a)(17).

(l) Service Purchases under Section 415(n). Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, if a member makes one or more contributions to purchase permissive service credit under the retirement system, then the requirements of Internal Revenue Code Section 415(n) will be treated as met only if:

(1) the requirements of Internal Revenue Code Section 415(b) are met, determined by treating the accrued benefit derived from all such contributions as an annual benefit for purposes of Internal Revenue Code Section 415(b), or

(2) the requirements of Internal Revenue Code Section 415(c) are met, determined by treating all such contributions as annual additions for purposes of Internal Revenue Code Section 415(c).

(3) For purposes of applying this section, the retirement system will not fail to meet the reduced limit under Internal Revenue Code Section 415(b)(2)(C) solely by reason of this subparagraph and will not fail to meet the percentage limitation under Internal Revenue Code Section 415(c)(1)(B) solely by reason of this section.

(4) For purposes of this section the term "permissive service credit" means service credit

(A) recognized by the retirement system for purposes of calculating a member's benefit under the retirement system,

(B) which such member has not received under the retirement system, and

(C) which such member may receive only by making a voluntary additional contribution, in an amount determined under the retirement system, which does not exceed the amount necessary to fund the benefit attributable to such service credit.

(5) Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, such term may include service credit for periods for which there is no performance of service, and, notwithstanding paragraph (4), subparagraph (B), may include service credited in order to provide an increased benefit for service credit which a member is receiving under the retirement system.

(6) The retirement system will fail to meet the requirements of this section if

(A) more than five years of nonqualified service credit are taken into account for purposes of this subparagraph, or

(B) any nonqualified service credit is taken into account under this paragraph before the member has at least five years of participation under the retirement system.

(7) For purposes of paragraph (6), effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, the term "nonqualified service credit" means permissive service credit other than that allowed with respect to

(A) service (including parental, medical, sabbatical, and similar leave) as an employee of the Government of the United States, any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing (other than military service or service for credit which was obtained as a result of a repayment described in Internal Revenue Code Section 415(k)(3)),

(B) service (including parental, medical, sabbatical, and similar leave) as an employee (other than as an employee described in subparagraph (A)) of an education organization described in Internal Revenue Code Section 170(b)(1)(A)(ii) which is a public, private, or sectarian school which provides elementary or secondary education (through grade 12), or a comparable level of education, as determined under the applicable law of the jurisdiction in which the service was performed,

(C) service as an employee of an association of employees who are described in subparagraph (A), or

(D) military service (other than qualified military service under Internal Revenue Code Section 414(u)) recognized by the retirement system.

(8) In the case of service described in paragraph (7), subparagraph (A), (B), or (C), such service will be nonqualified service if recognition of such service would cause a member to receive a retirement benefit for the same service under more than one plan.

(9) In the case of a trustee-to-trustee transfer after December 31, 2001, to which Internal Revenue Code Section 403(b)(13)(A) or Internal Revenue Code Section 457(e)(17)(A) applies (without regard to whether the transfer is made between plans maintained by the same employer):

(A) the limitations of paragraph (6) will not apply in determining whether the transfer is for the purchase of permissive service credit, and

(B) the distribution rules applicable under federal law to the system will apply to such amounts and any benefits attributable to such amounts.

(10) For an eligible member, the limitation of Internal Revenue Code Section 415(c)(1) shall not be applied to reduce the amount of permissive service credit which may be purchased to an amount less than the amount which was allowed to be purchased under the terms of the retirement system as in effect on August 5, 1997. For purposes of this paragraph an eligible member is an individual who first became a member in the retirement system before January 1, 1998.

(11) Nothing in this subsection (l) shall provide any additional rights to purchase service credit in the retirement system that are not otherwise expressly provided for under other provisions of these rules or Oklahoma statutes.

(m) Modification of Contributions for 415(c) and 415(n) Purposes.Notwithstanding any other provision of law to the contrary, the retirement system may modify a request by a member to make a contribution to the retirement system if the amount of the contribution would exceed the limits provided in Internal Revenue Code Section 415 by using the following methods:

(1) If the law requires a lump sum payment for the purchase of service credit, the retirement system may establish a periodic payment plan for the member to avoid a contribution in excess of the limits under Internal Revenue Code Section 415(c) or 415(n), pursuant to OAC 715:10-5-4.

(2) If payment pursuant to subparagraph (1) will not avoid a contribution in excess of the limits imposed by Internal Revenue Code Section 415(c) or 415(n), the retirement system may either reduce the member's contribution to an amount within the limits of those sections or refuse the member's contribution. The rules applicable to

picked-up service purchases under OAC 715:10-5-35 are not subject to this subsection.

(n) Repayments of Cashouts. Any repayment of contributions (including interest thereon) to the retirement system with respect to an amount previously refunded upon a forfeiture of service credit under the retirement system or another governmental plan maintained by the retirement system shall not be taken into account for purposes of Internal Revenue Code Section 415, in accordance with applicable Treasury Regulations.

(o) Reduction of Benefits Priority Reduction of benefits and/or contributions to all plans, where required, shall be accomplished by first reducing the member's benefit under any defined benefit plans in which the member participated, such reduction to be made first with respect to the plan in which the member most recently accrued benefits and thereafter in such priority as shall be determined by the plan and the plan administrator of such other plans, and next, by reducing or allocating excess forfeitures for defined contribution plans in which the member participated, such reduction to be made first with respect to the plan in which the member most recently accrued benefits and thereafter in such priority as shall be established by the plan and the plan administrator for such other plans provided, however, that necessary reductions may be made in a different manner and priority pursuant to the agreement of the plan and the plan administrator of all other plans covering such member.

## SUBCHAPTER 17. POST-RETIREMENT EMPLOYMENT

**715:10-17-6. Earnings limits**

The earnings limit for post-retirement earnings shall be one-twelfth (1/12) of the annual limit multiplied by the number of months the member is eligible to work and receive payments during each calendar year from the public schools of Oklahoma.~~The~~All other limitations on post-retirement earnings shall be administered as directed in Title 70, Oklahoma Statutes, Section 17-116.10 [70 O.S. 17-116.10].

## SUBCHAPTER 23. STATE AND EDUCATION EMPLOYEES GROUP HEALTH AND DENTAL INSURANCE PROGRAM

**715:10-23-6. Health Insurance Contribution**

(a) The Oklahoma Teachers' Retirement System shall contribute the amount required by law towards the cost of health insurance coverage under the State and Education Employees Group Insurance Plan or other eligible group insurance plans only for retired members who actually receive a monthly retirement benefit for that month. This contribution shall not be made for beneficiaries, survivors or directly to the retired member.

(b) For eligible group health insurance plans other than the State and Education Employees Group Insurance Plan, the System will contribute the amount required by law after the group insurance plan has made application to the System and completed any necessary and required forms and/or agreements. The group insurance plan must be in compliance with Oklahoma law and offer insurance to all of the covered participating employer's employees, former employees who are vested and former employees who retired from that covered employer. The insurance plan shall provide a certification monthly detailing each covered retired member in the form and manner required by the System. The subsidy shall be paid in arrears for each eligible retired member.

(c) As provided under 70 O.S. Section 17-108(13), and pursuant to the federal Internal Revenue Code Section 401(h) and Treasury Regulation §1.401-14, the Retirement Medical Benefit Fund shall be maintained as a sub-account of the Retirement Benefit Fund. From the Retirement Medical Benefit Fund, the System shall remit the amount specified in 74 O.S. Section 1316.3 for health insurance premiums.

(d) All contributions to the Retirement Medical Benefit Fund shall be reasonable and ascertainable.

(e) Contributions to the Retirement Medical Benefit Fund must be subordinate to the contributions to the Retirement Benefit Fund for retirement benefits. At no time shall the aggregate actual contributions to the Retirement Medical Benefit Fund (when added to actual contributions for life insurance protection under the plan, if any) be in excess of twenty-five percent (25%) of the total aggregate actual contributions made to the Retirement Benefit Fund (not including contributions to fund past service credits). The Board shall annually determine whether the twenty-five (25%) test has been met. If at any time the Retirement Medical Benefit Fund contributions (plus any life insurance contributions) would exceed the twenty-five percent (25%) test, the excess amount of contributions shall be transferred to the Retirement Benefit Fund for retirement benefits.

(f) Forfeitures in the Retirement Medical Benefit Fund shall not be allocated to individual accounts under the fund, but shall be used for account expenses.

(g) At no time prior to the satisfaction of all liabilities under the Retirement Medical Benefit Fund or termination of the fund shall any assets in the fund be used for, or diverted to, any purpose other than the providing of payment of the System's portion of the monthly retiree health insurance premium benefit described by Title 74 O.S. Section 1316.3 and the payment of administrative expenses. Assets in the Retirement Medical Benefit Fund may not be used for retirement or disability benefits or any other purposes for which other assets held in the Retirement Benefit Fund are used.

(h) The provisions of section 401(h)(5) of the Internal Revenue Code of 1986, as amended from time to time, shall apply upon the satisfaction of all liabilities under law and the Retirement Benefit Fund.

*[OAR Docket #13-915; filed 5-24-13]*

# TITLE 770. OKLAHOMA DEPARTMENT OF VETERANS AFFAIRS
# CHAPTER 1. ADMINISTRATIVE OPERATIONS

*[OAR Docket #13-912]*

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**RULES:**
Subchapter 1. General Provisions
710:1-1-1 [AMENDED]
770:1-1-2 [NEW]
770:1-1-3 [NEW]
Subchapter 3. Organizational Structure
770:1-3-1 [AMENDED]
Subchapter 5. Open Records Act
770-1-5-1 [AMENDED]
**AUTHORITY:**
War Veterans Commission; 72 O.S. §§ 63.1, 63.3, 202, 223, 75 O.S. § 307; 51 O.S. § 24A.5.
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**ANALYSIS:**
Revisions to Subchapter 1 delete references to Appendix A, which has previously been revoked, adds rules for request for declaratory rulings required by 75 O.S. § 307, and adds a rule to comply with Title 38, Part 51 of the Code of Federal Regulations relating to requirements to receive per diem from the U. S. Department of Veterans Affairs. Revisions to Subchapter 3 identify where domiciliary care is available, make the language gender neutral, and add the Claims office at each center to the list of claims and counseling services. Revisions to Subchapter 5 clean up statutory references.
**CONTACT PERSON:**
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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

**770:1-1-1. Purpose**

The purpose of this Chapter is to comply with the requirements of the Administrative Procedures Act, 75 O.S., Sections 302, 305 and 307; to publish the organization of the War Veterans Commission, the responsibility and authority by law placed on the Commission; and to clarify, identify and set forth the overall objectives of the veterans program in Oklahoma under existing law. ~~It contains the Table of Organization and chain of command for the Department of Veterans Affairs, under the control of the War Veterans Commission, as Appendix A of this Chapter.~~

**770:1-1-2. Request for interpretation of rules**

Any person who may be affected by the existence of application of any of the rules of the Oklahoma Department of Veterans Affairs may request in writing an interpretation of the ruling regarding the application of such rule to the facts furnished with the inquiry. Any such request shall state fully the facts concerning which the rule may apply, and the particular rule about which the question exists. The request or inquiry will be added to the agenda for the next scheduled Commission meeting and may, if necessary, be continued for further consideration to additional meetings. The Commission's interpretation of the rule will be furnished in writing to the person making the request within a reasonable time thereafter.

**770:1-1-3. Compliance with Title 38 of the Code of Federal Regulations**

The Oklahoma Department of Veterans Affairs will comply with all regulations of the U.S. Department of Veterans Affairs, under Title 38, Part 51, Per Diem for Nursing Home Care of Veterans in State Homes, including, but not limited to, a statement of resident's rights; admission, transfer and discharge rights; and resident behavior and facility practices. The Executive Director will develop policies and procedures to ensure compliance.

## SUBCHAPTER 3. ORGANIZATIONAL STRUCTURE

**770:1-3-1. Program description**

The present program for Oklahoma veterans is:

(1) To provide medical, nursing and domiciliary care (if available) for those veterans when needed. The Centers to accomplish this are:

(A) Ardmore
(B) Claremore
(C) Clinton (domiciliary)
(D) Lawton
(E) Norman
(F) Sulphur
(G) Talihina

(2) To provide financial assistance in emergencies to disabled or destitute veterans and to their ~~wives~~spouses, ~~widows~~surviving spouses, orphans and needy children. This is accomplished through Emergency Aid.

(3) To provide as complete rehabilitation as possible to disabled veterans and dependents:

(A) Claims and counseling services through:

(i) Claims Office, Muskogee, Oklahoma

(ii) Hospital Office, Muskogee, Oklahoma

(iii) Hospital Office, Oklahoma City, Oklahoma

(iv) Claims Office, Lawton, Oklahoma

(v) Clinic Office, Tulsa, Oklahoma

(vi) Itinerant Field Service Offices

(vii) Referral service to other agencies

(viii) Claims office at each center

(B) Education and training through schools, apprenticeship and on-job training establishments to be approved by the State Accrediting Agency.

## SUBCHAPTER 5. OPEN RECORDS ACT

### 770:1-5-1. Program description, compliance standard and basis for exemptions

(a) Section 24A.4 of Title 51 of the Oklahoma Statutes, **Oklahoma Open Records Act** specifically states that "in addition to other records which are kept or maintained, every public body and public official has a specific duty to keep and maintain complete records of the receipt and expenditure of any public funds reflecting all financial and business transactions relating thereto, except that such records may be disposed of as provided by law." [51 O.S.~~Supp. 1985, Section~~§24A.4]

(b) The Records Disposition Schedule for the Oklahoma Department of Veterans Affairs, (a copy of the Schedule is on file in the Central Office of the Department) lists and provides authority for the disposition of all records of the Department. No record as defined by Section 24A.3 (1) of Title 51 shall be disposed of in any manner other than that authorized by said Schedule.

(c) It is the policy of the War Veterans Commission as the controlling board for the Oklahoma Department of Veterans Affairs that no person shall be denied access to a record of the Department and that Title 51, Chapter 1 of the Oklahoma Statutes shall be complied with in accordance with the procedures set out in the rules of this Chapter.

(d) If any provision of this procedure or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

(e) All records of the Oklahoma Department of Veterans Affairs shall be open to any person for inspection, copying, and/or mechanical reproduction during regular business hours with the exception of those records identified in this Subchapter. Generally, exempt records can be classified as follows:

(1) Records specifically required by law to be kept confidential including:

(A) records not discoverable under state law such as material prepared in anticipation of litigation or trial; or

(B) records protected by a state evidentiary privilege such as the attorney-client and the identity of informer privileges; or

(C) records of what transpired during meetings of a public body lawfully closed to the public such as executive sessions authorized under the Oklahoma Open Meeting Act.

(2) Any reasonably segregable portion of a record containing exempt material shall be provided after deletion of the exempt portions.

*[OAR Docket #13-912; filed 5-24-13]*

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# TITLE 770. OKLAHOMA DEPARTMENT OF VETERANS AFFAIRS
# CHAPTER 10. CENTER DIVISION PROGRAM

*[OAR Docket #13-913]*

**RULEMAKING ACTION:**
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**RULES:**
Subchapter 1. General Provisions
770:10-1-3. Eligibility requirements [AMENDED]
770:10-1-4. Admission priorities and procedures [AMENDED]
Subchapter 3. Maintenance Charges, Patient Funds and Assets
770:10-3-2. Patient funds [AMENDED]
770:10-3-3. Disbursement of deceased patients' assets [AMENDED]

**AUTHORITY:**
War Veterans Commission; 72 O.S. §§ 63.1, 63.3, 63.5, 202, 222, 223, 225; and Title 38, Part 51 of the Code of Federal Regulations

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**ANALYSIS:**
Revisions to Subchapter 1 provide gender-neutral language, add clarification for eligibility requirements, and include priority for admittance of spouse and surviving spouse of eligible war-time veterans. Revisions to Subchapter 3 bring language into compliance with statutes, increases the amount patients can maintain in personal funds, and clarifies language related to whom accounting is made of a deceased patients' funds.

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

## SUBCHAPTER 1. GENERAL PROVISIONS

**770:10-1-3. Eligibility requirements**

To be eligible for admission to an Oklahoma Veterans Center, an individual must meet the definition of a War Veteran as defined in 72 O.S., Section 224 and/or as certified by the United States Department of Veterans Affairs for receipt of per diem payment and such other dates as may be established by U.S. Congress, Oklahoma Legislature or Oklahoma War Veterans Commission.

(1) Veterans must have served at least ninety (90) days, except where discharged due to or as a result of a service connected disability, with one or more days being during a wartime period as prescribed in (1) of this subsection. (Oklahoma Statutes, Title 72.)

(2) A veteran must be disabled by age, disease or other reason to be eligible for admission. For domiciliary, he/she must be ambulant, be able to dress himself or herself and perform necessary bathroom needs and share in some measure in the maintenance of his or her living area. For nursing care, he/she must be disabled or diseased to a degree that requires intermediate or skilled type nursing care.

~~(3) Any domiciliary member discharged by his own request will not be readmitted to any of the Centers until thirty days have expired from date of discharge.~~

**770:10-1-4. Admission priorities and procedures**

(a) It is the intent of the War Veterans Commission to establish a fair and equitable system and one that allows for the flexibility necessary in the operation of long-term nursing care facilities whereby eligible veterans may be placed on waiting lists for admission to the Oklahoma Veterans Centers operated by the Oklahoma Department of Veterans Affairs.

(b) Priorities for placement are as follows:

(1) Eligible World War II veterans seeking admission will be placed at the top of the waiting list and will be admitted to the first available bed capable of providing the level of care they require. When there are no longer living World War II veterans seeking admission, veterans of the next oldest wartime period will be placed at the top of the waiting list and will be admitted to the first available bed capable of providing the level of care they require and so on through established wartime periods.

(2) Eligible Ex-Prisoners of War and veterans rated service connected by the United States Department of Veterans Affairs will be placed at the top of the waiting list if there are no eligible veterans on the waiting list in category (1) above, and will be admitted to the first available bed capable of providing the level of care they require.

(3) All eligible veterans not specified in (1) or (2) of this subsection will be placed on the waiting list in chronological order based on the date of receipt of the application. If more than one application is received on the same day, the Medical Director will determine their sequential order on the list according to medical need. The veterans will be called from this list and will be admitted to the first available bed capable of providing the level of care they require.

(c) The admission priorities as set forth in (b) of this Section are to be adhered to as closely as possible; however, the Administrator of each Veterans Center must maintain the flexibility of being allowed to deviate from the waiting list when medical or humanitarian need dictates.

(d) Applications for admission are provided by writing or calling the Oklahoma Department of Veterans Affairs Center as follows:

(1) Ardmore - Administrator, Oklahoma Veterans Center Box 489, Ardmore, Oklahoma 73402 Telephone: Area Code (580) 223-2266

(2) Claremore - Administrator, Oklahoma Veterans Center P. O. Box 988, Claremore, Oklahoma 74018 Telephone: Area Code (918) 342-5432

(3) Clinton - Administrator, Oklahoma Veterans Center Box 1209, Clinton, Oklahoma 73601 Telephone: Area Code (580) 331-2200

(4) Lawton/Ft. Sill Division - Administrator, Oklahoma Veterans Center P. O. Box 849, Lawton, Oklahoma 73502 Telephone: Area Code (580) 351-6511

(5) Norman - Administrator, Oklahoma Veterans Center Box 1668, Norman, Oklahoma 73070 Telephone: Area Code (405) 360-5600

(6) Sulphur - Administrator, Oklahoma Veterans Center 304 E. Fairlane, Sulphur, Oklahoma 73086 Telephone: Area Code (580) 622-2144

(7) Talihina - Administrator, Oklahoma Veterans Center P. O. Box 1168, Talihina, Oklahoma 74571 Telephone: Area Code (918) 567-2251

(8) Oklahoma City Central Office - P.O. Box 53067, Oklahoma City, Oklahoma 73152 Telephone: Area Code (405) 521-3684

(9) Other applications for admission can be obtained at USDVA Medical Centers in Muskogee and Oklahoma City and through Oklahoma Department of Veterans Affairs Service Officers.

(e) Spouses and surviving spouses may be admitted on exhaustion of placement of all eligible war-time veterans.

## SUBCHAPTER 3. MAINTENANCE CHARGES, PATIENT FUNDS AND ASSETS

**770:10-3-2. Patient funds**

(a) It shall be the policy of the Oklahoma Veterans Centers to maintain special accounts (patients personal funds) for the patients. Said accounts will be maintained solely for the convenience of the patient. The Oklahoma Veterans Centers

should not be construed as serving in a fiduciary capacity over these accounts.

(b) No patient shall be required to maintain a patients funds account; however, if the patient wishes to use this service, he/she will be allowed to keep an amount not to exceed $~~100.00~~2,500.00 in their account.

(c) In the event the dollar amount exceeds the maximum allowable in the account, the following action will be taken:

(1) Competent patients: The patient will be contacted by the finance office advising them of the excess and instructing that they transfer the excess within two (2) weeks.

(2) Incompetent patients with guardians or payees: The guardian/payee will be notified by letter advising them of the excess and instructing them to make arrangements for transfer of the excess funds within one (1) month.

**770:10-3-3. Disbursement of deceased patients' assets**

(a) The Oklahoma Veterans Centers, subdivision of the Oklahoma Department of Veterans Affairs, shall release deceased patients' personal effects and funds only after proper legal instruments have been presented to the Oklahoma Veterans Center concerned.

(b) Upon presentation of said legal instruments, an accounting of the deceased patients' funds will be made to the executor, administrator or personal representative. If the deceased patient owes any monies to the Oklahoma Veterans Center, a billing will be presented to the executor, administrator or personal representative and copies to the court having jurisdiction.

(c) Nothing in this policy shall preclude an Oklahoma Veterans Center from providing clothing necessary for burial of a veteran to the person or persons responsible for finalizing burial arrangements.

(d) During the admission process, this ~~new~~ procedure will be fully explained to the patient, their spouse and/or persons named as the patients' designee ~~on OVC Form #21, "Patients Information Record"~~.

*[OAR Docket #13-913; filed 5-24-13]*

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## TITLE 770. OKLAHOMA DEPARTMENT OF VETERANS AFFAIRS
## CHAPTER 15. CLAIMS AND BENEFITS DIVISION PROGRAM

*[OAR Docket #13-914]*

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**RULES:**
Subchapter 1. General Provisions
770:15-1-1. Purpose [AMENDED]
Subchapter 3. Claims Services
770:15-3-2. Disaster assistance [AMENDED]
770:15-3-3. Hunting and fishing licenses [AMENDED]
Subchapter 5. Emergency Financial Assistance
770:15-5-1. Eligibility for financial assistance [AMENDED]
770-15-5-3. Policies and basis for claims [AMENDED]

**AUTHORITY:**
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**ANALYSIS:**
Revisions to Subchapter 1clean up statutory references. Revisions to Subchapter 2 clean up statutory references, delete requirements that assistance is only available when the National Red Cross does not participate; add disasters declared by the Governor; clarify language that local officials are oficials of veteran service organizations. Revisions to Subchapter 5 make language gender neutral, scrivener errors, and clean up references to the Executive Director and bring language in compliance with 72 O.S. § 67.13; clarifies impact of emergency aid. on DHS benefits; and provide Executive Director has final approval of who may present cases to the War Veterans Commission.

**CONTACT PERSON:**
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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 27, 2013:**

### SUBCHAPTER 1. GENERAL PROVISIONS

**770:15-1-1. Purpose**

The purpose of this Chapter is to:

(1) Effect new policy and procedure in the Claims Office as it pertains to the Hospital Officers and Veterans Service Officers regarding claims work, and set forth a basic guide for the Claims and Hospital Officers to observe in the performance of their duties.

(2) Establish a clear-cut policy for the Veterans Service Officers and other personnel to follow when there is a tornado, flood or other disaster where this department may render financial or other assistance.

(3) Clarify the question of eligibility requirements for a veteran to receive a free hunting and fishing license.

(4) Set forth the basic policy on securing documents to support a veterans claim with the Veterans Administration.

(5) Promulgate the rules and procedures of the Oklahoma War Veterans Commission under the authority of 72 O.S.~~, Section~~§67.13 for administering the emergency financial aid program by the Department of Veterans Affairs and establish a policy on minimum amount of time and type of discharges from the military service.

## SUBCHAPTER 3. CLAIMS SERVICES

### 770:15-3-2. Disaster assistance

(a) The following procedure will be observed by the Veterans Service Officers in whose territory a disaster occurs and is so declared by the President or branch of the federal government or the Governor of the State of Oklahoma as being a major disaster area ~~and the National American Red Cross participates~~.

(1) Advise the local officials~~,~~and individual veterans ~~and officials of the American Red Cross~~ that this department will work with other sources from various agencies to render financial assistance. This department can give assistance in conjunction with resources from various agencies and service organizations, but a qualifying veteran is not required to wait~~cannot render financial assistance~~ until all other resources from various agencies have been completed. ~~Only then will the~~The Department of Veterans Affairs will render financial assistance in keeping with the ~~standard~~rules and policies of the War Veterans Commission on the expenditure of child welfare and emergency aid funds.

(2) Advise the local veteran service organization officials and veterans as much as possible on help that can be secured through the American Red Cross. When the disasters are over, financial assistance may be rendered by the Department of Veterans Affairs in the normal manner with applications and upon recommendations of the local ~~post~~veteran service organization. Veterans Service Officers will render every assistance possible to local officials by assisting in completing the application forms except the investigation and recommendation, which is to be handled and made by the local officials.

~~(b) The procedure in (a) of this section will be followed on local disasters except immediate financial assistance applications may be taken, where the National Red Cross is not participating.~~

(~~c~~b) The Managers and other officials of the Centers will render every assistance possible in the event of local disasters in their communities. Likewise, the Claims Officers and Hospital Officers will assist in the event disasters occur in their towns.

### 770:15-3-3. Hunting and fishing licenses

Hunting and fishing licenses will be issued by the Headquarters Office or the Claims Office only. Applications received by the field staff or hospital officers will be forwarded to the Claims Office for action. Each eligible veteran should be informed that the license issued by this department does not apply to special licenses or permits such as a duck stamp or commercial fishing license. To be valid, each permit issued must have the official seal of the War Veterans Commission of Oklahoma affixed to it. 29 O. S.~~, Section~~§4-110(B)(3)~~-~~(4) provides that any legal resident of the State over the age of sixty-five (65) years and all disabled veterans of sixty percent (60%) disability or more who are legal residents of the State shall be exempt from the license requirements of the Act.

## SUBCHAPTER 5. EMERGENCY FINANCIAL ASSISTANCE

### 770:15-5-1. Eligibility for financial assistance

(a) To be eligible for emergency financial assistance through the Oklahoma Department of Veterans Affairs, a war-time veteran must be honorably discharged and otherwise meet the following, pursuant to 72 O.S. § 67.13:

(1) Meet the definition of a War Veteran as defined in 72 O.S.~~, Section~~§224.

~~(2) Have ninety (90) days of actual wartime service. Proof of service is required. Wartime dates are as follows:~~

~~(A) World War I - 04/06/17 to 11/11/18 (Both dates inclusive)~~

~~(B) World War II - 12/07/41 to 12/31/46 (Both dates inclusive)~~

~~(C) Korean Conflict - 06/27/50 to 01/31/55~~

~~(D) Vietnam Era - 08/05/64 to 05/07/75, or~~

~~(E) Who served in the military or naval forces of the United States on or after June 25, 1950, during the period of time in which the United States participated in a war, military or naval campaign, or expedition.~~

(~~3~~2) Have ~~three (3)~~one (1)~~years~~year residence in the State of Oklahoma immediately prior to date of application for emergency aid.

(b) Other than death cases, a medical statement showing the veteran's inability to work is required for payment of emergency aid. No medical statement is required for emergencies involving disasters such as fire, flood or storm damage to the home.

(c) The ~~widow or minor child's eligibility is based on the veteran's wartime service; however, on child welfare, the guardian or custodian of the child must have three (3) years residence as required in (3) of subsection (a) of this section~~spouse or surviving spouse of an eligible veteran may also be eligible for emergency financial assistance. The spouse or surviving spouse must have one (1) year residence in the State of Oklahoma prior to date of application for emergency aid.

### 770:15-5-3. Policies and basis for claims

(a) $1,000.00 is the maximum amount payable to a family in any one fiscal year.

(b) Payments are made only in cases where there is a temporary emergency due to illness, disability, death or disaster. In the event of desertion, an affidavit from the spouse is required.

(c) Unemployment is not a basis for payment of emergency aid funds. If the veteran has not been employed previous to the application for emergency aid and has been unemployable or retired, then illness or injury cannot be used as reason for the emergency.

(d) The handling, allowing, disallowing and supervision of emergency aid funds are vested in the Headquarters office with the Executive Director. The decisions will be made by a panel of at least three members from the Central Office and/or Claims Office staff and recommendation made to the Executive Director for his or her final approval. The Executive Director, at his or her sole discretion, may present cases to the War Veterans Commission.~~Controversial cases or matters~~Matters of policy are presented to the Commission.

(e) In cases where the applicants misrepresent length of residence or income, the Executive Director makes a complete investigation of the case before payment is made. If there is fraud connected with the case, it is referred to the War Veterans Commission with a recommendation from the Executive Director. The War Veterans Commission may suspend future eligibility of the applicants and may refer unusual cases to the Attorney General for appropriate action.

(f) Claimants who have applied for emergency aid more than once will have their files closely reviewed to determine if the claimant is attempting to obtain funds from the emergency aid program as a continuing source of yearly income. Apparent claims of this nature will be referred back to the post service officer for further investigation or will be denied if so determined by the reviewing panel or the Executive Director.

(g) Emergency aid will not be granted where regular monetary benefits are received from the Department of Human Services, ~~as~~if Oklahoma Department of Veterans Affairs emergency aid would cause the Department of Human Services benefits to be discontinued.

(h) Residence outside the state for purposes of Veterans Administration hospitalization or domiciliary care does not count against the veteran to meet the one year residence immediately prior to application. Cases of this nature will be handled on an individual basis. The intent should be the controlling factor in arriving at a determination of eligibility.

(i) In the event of a hardship created by an illness where the veteran is not employed (see (c) of this section); or by loss of a V.A., Social Security, retirement check, etc., the circumstances will be reviewed with consideration given to the humanitarian outcome if denied.

(j) The Oklahoma Department of ~~veterans~~Veterans Affairs will establish internal operating procedures for the expeditious processing of emergency aid claims.

(k) The procedures in (a) through (j) of this Section may include the development of forms, letters of instruction to veterans services organization post service officers, checklists for the use of review panels, and correspondence to claimants.

(l) The Department of Veterans Affairs will accept the discharge or statement of service in determining eligibility for financial assistance. Unless the veteran has a service connected disability as certified by the Veterans Administration or the appropriate branch of military service, he must have ninety days continuous service extending into or out of wartime in order to be eligible. Honorable discharges are accepted without question. For Bad Conduct, Undesirable and other types, the department will ask the Veterans Administration for a determination as to whether or not the veteran was discharged under other than dishonorable conditions.

*[OAR Docket #13-914; filed 5-24-13]*

## TITLE 795. OKLAHOMA WHEAT COMMISSION
## CHAPTER 1. ADMINISTRATIVE OPERATIONS

*[OAR Docket #13-825]*

**RULEMAKING ACTION**
Permanent Final Adoption
**RULES:**
795:1-1-4 [AMENDED]
795:1-1-5 [AMENDED]
**AUTHORITY:**
Oklahoma Wheat Commission
Oklahoma Wheat Resources Act; 2 O.S. §§ 18-300 et seq.
**DATES:**
**Comment period:**
October 15, 2012 through November 19, 2012
**Public hearing:**
December 19, 2012
**Adoption:**
March 7, 2013
**Submitted to the Governor:**
March 12, 2013
**Submitted to the House:**
March 12, 2013
**Submitted to the Senate:**
March 12, 2013
**Gubernatorial approval:**
March 25, 2013
**Legislative Approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 9, 2013
**Final Adoption:**
May 9, 2013
**Effective:**
July 1, 2013
**SUPERSEDED RULES:**
NA
**INCORPORATION BY REFERENCE:**
NA
**ANALYSIS:**
The proposed rule changes ensure wheat producers have a voice in electing a new wheat commission board member if an unforeseen vacancy should occur before the term is up with a current appointee, and changes the election time from 2:00 p.m. to1:00 p.m. These rules affect the wheat growers in the state by giving them a greater opportunity to have a voice in the people they want elected to the Oklahoma Wheat Commission Board. It also moves the election time up for district elections to be more convenient for wheat producers.
**CONTACT PERSON:**
Mike Schulte, Executive Director, Oklahoma Wheat Commission, email: mike.schulte@wheat.ok.gov, 3800 North Classen Blvd. Suite C-40, Oklahoma City, OK 73118, phone: 1-405-608-4350

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

**795:1-1-4. Commission membership**

(a) With the exception of the ex-officio members, the Governor shall appoint a Commission to be known as the Oklahoma Wheat Utilization, Research and Market Development Commission who shall advise and direct the Director of the Wheat Utilization, Research and Market Development Commission.

(b) The Commission shall be composed of five (5) members who:

(1) Are at least twenty-five (25) years of age and a resident of Oklahoma.

(2) Have been actually engaged in growing wheat in this state for a period of at least five (5) years; and;

(3) Derive a substantial portion of their income from growing wheat.

(c) The five members of the Commission, referred to in subsections (a) and (b) of this section, shall be residents of and have farming operations in those areas of the state designated as Districts I through V, one from each District.

(1) District I, consisting of Alfalfa, Garfield Grant and Major counties.

(2) District II, consisting of Beaver, Cimarron, Ellis, Harper, Texas, Woods, and Woodward counties.

(3) District III, consisting of Beckham, Blaine, Canadian, Custer, Dewey, Kingfisher, Roger Mills, and Washita counties.

(4) District IV, consisting of Caddo, Comanche, Cotton, Greer, Harmon, Jackson, Kiowa, and Tillman counties.

(5) District V, consisting of all counties east of the western boundary lines of Kay, Noble, Logan, Oklahoma, Cleveland, Grady, Stephens and Jefferson counties.

(d) The Governor shall appoint one member of the Commission for each of the districts established in subsection (c) of this section from lists of three nominees for each of said five (5) Districts as selected by the wheat producers of each District in meetings called by the Oklahoma Wheat Utilization, Research and Market Development Commission. All producers who have paid a fee and left it with the Commission during the current year, shall be eligible to vote in said meetings for their respective Districts; provided however, that all wheat producers in the state as defined in 795:1-1-3 shall be eligible to vote in the selection of nominees for the initial appointments to the Commission. It shall be the responsibility of the producer to prove his eligibility to vote.

(e) Ex-officio, non-voting members of the Commission referred to in subsection (a) of this section shall be the President of the Oklahoma State Board of Agriculture and the Director of the State Extension Service.

(f) As the terms of office of such appointees expire, their successors shall be appointed by the Governor for a term of five (5) years as provided in subsection (d) of this section. Each member shall hold office until his successor is appointed and has qualified. A member appointed to fill a vacancy occurring before the expiration of a term of a member separated from the Commission for any cause shall be appointed for the remainder of the term-of the member whose office has been vacated. ~~[2:1024 et seq.]~~

(g) If a vacancy occurs prior to the end of a term, the vacancy shall be filled pursuant to subsection (d) of this section.

**795:1-1-5. District election rules**

(a) Election will begin at ~~2:00~~1:00 p.m.

(b) All nominations will be made from the floor.

(c) There will be no nominating committees.

(d) No one person may nominate more than one name for a position.

(e) Nominations will be declared closed by the presiding officer after all nominations have been made.

(f) One secret ballot will be taken. Each qualified producer shall be eligible to vote for one nominee.

(g) The three candidates receiving the most number of votes during the one secret ballot will be the nominees whose names will be submitted to the Governor for selection of a Commission member. In case of a tie, a runoff will be held between the candidates involved in the tie vote. If a tie cannot be decided by a secret ballot, the nominee or nominees will be selected by lot.

(h) Any person nominated must agree to serve if appointed by the Governor.

(i) The presiding officer shall appoint three counters and shall designate one of them to record the votes for each candidate. The decision by a majority of the counters as to how each ballot shall be counted shall be final. Adequate watchers shall also be appointed.

(j) The presiding officer shall be the Chairman of the Oklahoma Wheat Commission. If the Chairman cannot be present, the presiding officer shall be the Vice-Chairman of the Commission, the Secretary-Treasurer of the Commission, or the Commissioner from the district holding the election.

(k) Adequate notice will be given of the date of an election.

(l) Eligibility to vote in an Oklahoma Wheat Commission District Election shall be: Each wheat producer who has paid his assessed fee and left the entire fee with the Commission during the current year shall be eligible to vote in the election for his respective district. It shall be the responsibility of the grower to provide proof of his eligibility to vote.

(m) Proof of voter eligibility shall include:

(1) a dated grain elevator receipt which includes the wheat producer's name and amount of wheat sold and

(2) a driver's license or some other form of identification.

*[OAR Docket #13-825; filed 5-17-13]*

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## TITLE 795. OKLAHOMA WHEAT COMMISSION
## CHAPTER 10. FUNDING TERMS

*[OAR Docket #13-826]*

**RULEMAKING ACTION**

Permanent Final Adoption

**RULES:**

795:10-1-3 [AMENDED]
795:10-1-4 [AMENDED]
795:10-1-8 [AMENDED]

**AUTHORITY:**
Oklahoma Wheat Commission
Oklahoma Wheat Resources Act; 2 O.S. §§ 18-300 et seq.
**DATES:**
**Comment period:**
October 15, 2012 through November 19, 2012
**Public hearing:**
December 19, 2012
**Adoption:**
March 7, 2013
**Submitted to the Governor:**
March 12, 2013
**Submitted to the House:**
March 12, 2013
**Submitted to the Senate:**
March 12, 2013
**Gubernatorial approval:**
March 25, 2013
**Legislative Approval:**
Failure of the Legislature to disapprove the rules resulted in approval on May 9, 2013
**Final Adoption:**
May 9, 2013
**Effective:**
July 1, 2013
**SUPERSEDED RULES:**
NA
**INCORPORATIONS BY REFERENCE:**
NA
**ANALYSIS:**
The proposed rule changes update the promotional fee; assessment and allocation; referendum to determine continuation of the fee; and refund process to follow the current law under the Wheat Resources Act. These rules affect the wheat producers in the state who support the Oklahoma Wheat Commission.
**CONTACT PERSON:**
Mike Schulte, Executive Director, Oklahoma Wheat Commission, email: mike.schulte@wheat.ok.gov, 3800 North Classen Blvd. Suite C-40, Oklahoma City, OK 73118, phone: 1-405-608-4350

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF JULY 1, 2013:**

### 795:10-1-3. Promotional fee; assessment and allocation

Any promotional fee, assessment or allocation shall comply with 2 O.S. § 18-308.

~~(a) *There is hereby assessed a fee of three fourths cent ($0.0075 per bushel upon all wheat marketed by wheat producers, as defined in this Chapter, in the State of Oklahoma and sold through commercial channels, beginning ninety (90) days after the act shall become effective. The fee is assessed and imposed on the producer at the time of sale or delivery, and shall be collected and remitted by the first purchaser to the Commission. Under provisions of the rules of the Commission, no wheat shall be subject to a fee more than once.*~~

~~(b) *The Commission shall allocate twenty percent (20%) of the three fourths cent ($0.0075) fee levied and collected pursuant to subsection (a) of this section, to the Oklahoma Wheat Research Foundation for the purpose of conducting wheat research, including utilization and educational projects, minus the cost of collecting the fee, such cost not to exceed fifty percent (50%) of the total of the office rental and clerical costs, and the costs of supplies and postage and such cost to be prorated on the basis of eighty percent (80%) to the Commission and twenty percent (20%) to the Oklahoma Wheat Research Foundation. In order for the Oklahoma Wheat Research Foundation to qualify for the allocation of twenty percent (20%) of collected fees, the Oklahoma Wheat Commission shall appoint a member of the Wheat Commission to the Oklahoma Wheat Research Foundation Board of Directors.* [2:1030)~~

### 795:10-1-4. Referendum to determine continuation of fee

Referendums to determine continuation of a fee shall follow the procedures set forth in 2 O.S. § 18-309.

~~(a) *Producers may petition for a referendum to determine if the assessment is to be continued, at any time after five (5) years following the effective date of the act. The President of the State Board of Agriculture shall call and conduct a referendum if said petitions bear signatures of ten percent (10%) of the wheat producers as defined within this Chapter. No more than one such referendum shall be conducted in any thirty-six (36) month period. The State Board of Agriculture shall determine if the petition bears the required number of valid signatures. The President shall announce the referendum at least thirty (30) days prior to the day of voting. At least thirty (30) days before the referendum the President shall mail a notice of said referendum to all known wheat producers in the State of Oklahoma who market wheat in commercial quantities. The notice shall specify the dates, times and places for holding the referendum, and shall include a sample ballot with this wording:*~~

| ~~*DO YOU FA VOR A CONTINUATION OF THE 71/2 MILL PER BUSHEL ASSESSMENT ON WHEAT MARKETED IN OKLAHOMA FOR UTILIZATION, RESEARCH, AND MARKET DEVELOPMENT?*~~ | |
|---|---|
| ~~*YES*~~_____ | ~~*NO*~~_____ |

~~(b) *Places within each county for conducting said referendum shall be designated by the Agricultural Extension Division of Oklahoma State University, and voting in each county shall be supervised by the county agricultural extension agent, or person designated by the extension division in cases where there is no county agent in a county at the time of referendum. The Commission shall insure sufficient ballots and supplies necessary for the conduct of the voting and tabulation of returns. Certified results of the referendum in each county shall be transmitted within twenty-four (24) hours after voting ends to the President of the State Board of Agriculture and the ballots themselves shall be transmitted to the President within forty-eight (48) hours. Ballots shall be preserved by the President for a period of at least three (3) months.*~~

~~(c) *The results of the referendum shall be determined by the President and the results certified to the Governor, who shall issue a proclamation declaring the results.*~~

~~(d) *The Commission shall bear expenses of advertising and conducting the referendum.*~~

~~(e) *Whenever the question of levying the assessments is disapproved, by failure of sixty percent (60%) of the producers voting in the referendum to favor continuation of the assessments, the proclamation declaring the result shall provide for the termination of the assessments on April 30, following the date of said referendum.*~~

~~(f) *Thirty (30) days after termination of the assessment, all remaining funds of the Commission shall be transferred to the Experiment Stations of Oklahoma State University, to be used for continued research on wheat. [2:1031]*~~

**795:10-1-8. Refunds**

*Any person, firm or corporation subject to the fee provided in this act ~~[2:1021 et seq.]~~ that objects to the collection of the fee may, within ~~one hundred twenty (120)~~ sixty (60) days following such collection, make application to the Director of the Commission for a refund of such fee and upon receipt of said application such refund shall be made within thirty (30) ~~days.~~ days of the date the refund request was received and the Commission received payment from the first purchaser. ~~Application forms for refund purposes shall be furnished by the Commission and shall be made available at all places where the fee provided in this act [2:1021 et seq.] is required to be collected [2:1035]~~*

*[OAR Docket #13-826; filed 5-17-13]*

# 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

**1:2013-18.**

### EXECUTIVE ORDER 2013-18

I, Mary Fallin, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution hereby establish the Juvenile Justice Reform Committee.

The purpose of the committee shall be to undertake a full and thorough study of Oklahoma's juvenile justice system and to recommend improvements to Oklahoma's system, the Oklahoma Juvenile Code in Title 10A of the Oklahoma Statutes, and any other statutes necessary to accomplish its purpose.

The Juvenile Justice Reform Committee shall consist of twelve (12) appointed members who have experience or an interest in juvenile justice issues including: one member who is a presiding judge of a court having juvenile law jurisdiction; one member who is the Executive Coordinator of the District Attorneys Council, or designee; one member who is the Executive Director of the Oklahoma Indigent Defense System, or designee; one member who is the Executive Director of the Office of Juvenile Affairs, or designee; one member who is the Director of the Oklahoma Commission on Children and Youth, or designee; one member representing an Oklahoma nonprofit organization whose membership consists solely of youth services agencies.

All members shall be appointed and serve at the pleasure of the Governor. The Governor shall select the chair who shall then select a vice-chair. The Speaker of the House of Representatives and the President Pro Tempore of the Senate are also invited to appoint one legislator each to serve as ex-officio members of the task force.

The Oklahoma Juvenile Justice Reform Committee shall conduct a systematic review of the juvenile justice system of Oklahoma; said review shall include consideration of the following issues related to the system's efficiency and effectiveness in protecting the public and habilitating and rehabilitating juveniles:

1. The most efficient organizational and effective programs for the juvenile justice system to accomplish its public safety, treatment and prevention goals including any agency programs which are antiquated or not consistent with best practices;
2. A review of other state's criminal justice systems, recommendations regarding the restructuring of Oklahoma's management system as well as any potential barriers to restructuring;
3. Oklahoma's recidivism rates and any systemic changes to help decrease this rate including possible use of risk assessments and evaluations at sentencing for every juvenile;
4. Oklahoma's diversion programs including an assessment of whether current programs could be better utilized;
5. National best practices concerning the housing and treatment of juveniles as well as any changes or improvements to Oklahoma's system;
6. Oklahoma's Youthful Offender Act and the most effective system to deal with youthful offenders;
7. All laws and procedures in Title 10A of the Oklahoma Statutes or other laws affecting the juvenile justice system including the laws relating to youthful offenders, certification and reverse certification of juveniles; and
8. Any fiscal impact associated with the recommendations.

The Oklahoma Juvenile Justice Reform Committee shall prepare a report of its recommendations and any legislative or administrative rule changes necessary to accomplish the recommendations.

The committee shall meet at such times and places as it deems appropriate. Members shall serve without compensation. Administrative support for the committee, including personnel necessary to ensure the proper performance of the duties and responsibilities of the committee, shall be provided by the Oklahoma Office of Juvenile Affairs.

All departments, officers, agencies and employees of this state shall cooperate with the Oklahoma Juvenile Justice Reform Committee in carrying out its duties and responsibilities, including providing any information, records and reports as may be requested by the Chair of the committee.

The committee shall report its findings to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives no later than January 1, 2014. This report shall include any recommendations approved by a majority of the members. This committee shall sunset upon issuance of its final report.

This Executive Order shall be distributed to the Secretary of Safety and Security, who shall cause the provisions of this Order to be implemented.

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 16th day of May, 2013.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Chris Morriss
Assistant Secretary of State

*[OAR Docket #13-823; filed 5-16-13]*

**1:2013-19.**

## EXECUTIVE ORDER 2013-19

I, Mary Fallin, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution hereby establish the Pipeline Safety Task Force.

The purpose of the task force shall be to study the issues related to pipeline safety and prevention of excavation damage. The Pipeline Safety Task Force shall consist of eleven (11) appointed members. All members shall be appointed by and serve at the pleasure of the Governor. At least eight (8) members shall be operators of pipeline facilities and excavators covered by the Oklahoma Underground Facilities Damage Prevention Act. The Governor shall select the chair who shall then select a vice-chair. The Speaker of the House of Representatives and the President Pro Tempore of the Senate are also invited to appoint one legislator each to serve as ex-officio members of the task force.

The task force shall assess pipeline safety and prevention of excavation damage in connection with the Pipeline Inspection, Protection, Enforcement and Safety Act of 2006, the Pipeline Safety Regulatory Certainty and Job Creation Act of 2011 relating to underground damage prevention programs and any Pipeline and Hazardous Materials Safety Administration rules resulting from authority granted under either act, including but not limited to:

1. Whether the Oklahoma Underground Facilities Damage Prevention Act is consistent with any final rules issued in the Pipeline and Hazardous Materials Safety Administration, Notice of Proposed Rulemaking, 49 C.F.R. Parts 196 & 198 (April 2, 2012);
2. The need to implement a complaint process under the regulatory authority of the Corporation Commission;
3. The adequacy of the current enforcement powers of the Commission;
4. The need to authorize the Commission to take enforcement action with respect to any of the following prohibited practices:
   a. excavation or demolition by an excavator without first notifying all operators in the geographic area, as required by law,
   b. failure by an excavator to employ excavation or demolition procedures specified by law,
   c. failure by an excavator to report damage to the operator as required by law,
   d. in the event of damage to a pipeline that results in the escape of any flammable, toxic, or corrosive gas or liquid that may endanger life or cause serious bodily harm or damage to property, failure to report the incident promptly to local 911 emergency authority,
   e. failure by a pipeline operator to report to the Commission those incidents involving its facilities as required by law,
   f. frivolous and malicious notifications to operators of pipelines, and
   g. repeated instances of any of these prohibited practices;
5. Whether providing enforcement authority requires clarifying the private rights-of-action provided by the Oklahoma Underground Facilities Damage Prevention Act; and
6. Any other issues the task force deems advisable.

The task force shall report its findings to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives no later than December 1, 2013. This report shall include the results of its assessment and any recommendations approved by a majority of the members.

If the Pipeline and Hazardous Materials Safety Administration has not issued final rules in Docket No. PHMSA-2009-0192 by December 1, 2013, then the task force shall issue its preliminary findings on December 1, 2013, and shall issue its final report thirty (30) days after the issuance of final rules in Docket No. PHMSA-2009-0192. This task force shall sunset upon issuance of its final report.

The task force shall meet at such times and places as it deems appropriate. Members shall serve without compensation. Administrative support for the task force, including personnel necessary to ensure the proper performance of the duties and responsibilities of the task force, shall be provided by the Oklahoma Corporation Commission.

This Executive Order shall be distributed to the Secretary of Energy, which shall cause the provisions of this Order to be implemented.

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 16th day of May, 2013.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Chris Morriss
Assistant Secretary of State

*[OAR Docket #13-824; filed 5-16-13]*

**1:2013-20.**

## EXECUTIVE ORDER 2013-20

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to the power vested in me by Section 2 of Article VI of the Oklahoma Constitution hereby declare the following:

1. Tornadoes, severe storms, straight-line winds and flooding beginning May 18, 2013 and continuing have caused extensive damage to public and private properties within the State of Oklahoma; and said damages have caused an undue hardship on the citizens of this state.
2. It may be necessary to provide for the rendering of mutual assistance among the State and political subdivisions of the State with respect to carrying out disaster emergency functions during the continuance of the State emergency pursuant to the provisions of the Oklahoma Emergency Management Act of 2003.
3. There is hereby declared a disaster emergency caused by the tornadoes, severe storms, straight-line winds and flooding in the State of Oklahoma that threatens the lives and property of the people of this State and the public's peace, health and safety. The counties included in this declaration are:

Caddo, Cleveland, Comanche, Creek, Garfield, Grant, Greer, Kiowa, Lincoln, Logan, McClain, Okfuskee, Oklahoma, Pawnee, Payne and Pottawatomie

This declaration may be amended to add counties as conditions warrant.

4. The State Emergency Operations Plan was activated on May 18, 2013 and resources of all State departments and agencies available to meet this emergency are hereby committed to the reasonable extent necessary to protect lives and to prevent, minimize, and repair injury and damage. These efforts shall be coordinated by the Director of the Department of Emergency Management with comparable functions of the federal government and political subdivisions of the State.
5. State agencies, in responding to this disaster emergency, may make necessary emergency acquisitions to fulfill the purposes of this proclamation without regard to limitations or bidding requirements on such acquisitions.
6. This Executive Order shall terminate at the end of thirty (30) days.

Copies of this Executive Order shall be distributed to the Director of Emergency Management who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, this 19th day of May 2013.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Larry V. Parman
Secretary of State

*[OAR Docket #13-830; filed 5-20-13]*

**1:2013-21.**

## EXECUTIVE ORDER 2013-21

I, Mary Fallin, 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 receipt of this Order on Tuesday, May 21, 2013, until 8:00 a.m. on Monday, May 27, 2013, in honor of those lost and injured by the May 19 and 20, 2013 tornadoes including those in Shawnee, Moore, Newcastle, and South Oklahoma City. Let this be a symbol to the nation of Oklahomans coming together to mourn, heal, and rebuild from the devastation created by this storm.

This executive order shall be forwarded to the Division of Capital Assets Management, 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 21st day of May, 2013.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Chris Morriss
Assistant Secretary of State

*[OAR Docket #13-870; filed 5-21-13]*

**1:2013-22.**

## EXECUTIVE ORDER 2013-22

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to the power vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution and 63 O.S. §§ 683.1 *et seq.*, hereby declare that because there is a state of emergency continuing in the State of Oklahoma due to catastrophic weather occurring statewide, it is necessary to assist and expedite all efforts of storm relief. In order to accommodate this need and to provide assistance to the citizens of Oklahoma in this extraordinary situation, I hereby order the temporary suspension of the following as they apply to vehicles used in the support effort:

1. The requirements for size and weights permits of oversized vehicles under Title 47 whose sole purpose is transportation of materials and supplies used for storm relief;
2. The requirements under parts 390 through 399 pursuant to part 390.23 of Federal Motor Carriers Safety Administration Regulations;
3. The requirements for licensing/operating authority as required by the Oklahoma Corporation Commission;
4. The requirements for licensing/registration as required by the Oklahoma Tax Commission;

Because of the on-going state of emergency resulting from the tornados on May 19th and 20th of 2013, this Executive Order shall be effective until the end of thirty (30) days after the filing of this Executive Order.

This Executive Order shall be forwarded to the Oklahoma Corporation Commission, the Oklahoma Tax Commission, and the Commissioner of Public Safety, 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 21st day of May, 2013.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Chris Morriss
Assistant Secretary of State

*[OAR Docket #13-871; filed 5-21-13]*

**1:2013-23.**

## EXECUTIVE ORDER 2013-23

I, Mary Fallin, Governor of the State of Oklahoma, in recognition of Memorial Day, 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 Monday, May 27, 2013, to honor those Americans who gave their lives for the freedom we enjoy today.

This executive order shall be forwarded to the Division of Capitol Assets Management 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 24th day of May, 2013.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Chris Morriss
Assistant Secretary of State

*[OAR Docket #13-932; filed 5-24-13]*