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Mary Fallin, Governor
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Board of Regents of NORTHERN Oklahoma College (<i>exempted 11-1-98</i>)	480	Oklahoma TURNPIKE Authority (<i>Formerly: Oklahoma TRANSPORTATION Authority AND Oklahoma TURNPIKE Authority) - <i>See</i> also Title 745</i>	735
Oklahoma Board of NURSING	485	State TREASURER	740
Oklahoma State Board of Examiners for LONG-TERM Care Administrators (<i>Formerly: Oklahoma State Board of Examiners for NURSING Home Administrators)</i>	490	Board of Regents of TULSA Community College (<i>exempted 11-1-98</i>)	740
Board of Regents of OKLAHOMA City Community College (<i>exempted 11-1-98</i>)	495	Oklahoma TURNPIKE Authority (<i>Name changed to Oklahoma TRANSPORATION Authority 11-1-99 - <i>no rules enacted in this Title - See</i> Title 731)</i>	745
Board of Regents of OKLAHOMA Colleges (<i>exempted 11-1-98</i>)	500	Oklahoma UNIFORM Building Code Commission	748
Board of Examiners in OPTOMETRY	505	Board of Trustees for the UNIVERSITY Center at Tulsa (<i>exempted 11-1-98</i>)	750
State Board of OSTEOPATHIC Examiners	510	UNIVERSITY Hospitals Authority	752
PARDON and Parole Board	515	UNIVERSITY Hospitals Trust	753
Oklahoma PEANUT Commission	520	Board of Regents of the UNIVERSITY of Oklahoma (<i>exempted 11-1-98</i>)	755
Oklahoma State PENSION Commission	525	Board of Regents of the UNIVERSITY of Science and Arts of Oklahoma (<i>exempted 11-1-98</i>)	760
State Board of Examiners of PERFUSIONISTS	527	Oklahoma USED Motor Vehicle and Parts Commission	765
Office of PERSONNEL Management	530	Oklahoma Department of VETERANS Affairs	770
Board of Commercial PET Breeders	532	Board of VETERINARY Medical Examiners	775
Oklahoma State Board of PHARMACY	535	Statewide VIRTUAL Charter School Board	777
PHYSICIAN Manpower Training Commission	540	Oklahoma Department of CAREER and Technology Education (<i>Formerly: Oklahoma Department of VOCATIONAL</i> and Technical Education)	780
Board of PODIATRIC Medical Examiners	545	Oklahoma WATER Resources Board	785
Oklahoma POLICE Pension and Retirement System	550	Board of Regents of WESTERN Oklahoma State College (<i>exempted 11-1-98</i>)	790
State Department of POLLUTION Control (<i>abolished 1-1-93</i>)	555	Oklahoma WHEAT Commission	795
POLYGRAPH Examiners Board	560	Department of WILDLIFE Conservation	800
Oklahoma Board of PRIVATE Vocational Schools	565	WILL Rogers and J.M. Davis Memorials Commission	805
State Board for PROPERTY and Casualty Rates (<i>abolished 7-1-06; see also Title 365</i>)	570	Oklahoma WORKERS' Compensation Commission	810
State Board of Examiners of PSYCHOLOGISTS	575		
Department of CENTRAL Services (<i>Formerly: Office of PUBLIC Affairs</i>)	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 (<i>exempted 11-1-98</i>)	607		
State REGENTS for Higher Education	610		
State Department of REHABILITATION Services	612		
Board of Regents of ROGERS State College (<i>exempted 11-1-98</i>)	615		

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 158. CONSTRUCTION INDUSTRIES BOARD **CHAPTER 1. PROCEDURES OF THE OKLAHOMA CONSTRUCTION INDUSTRIES BOARD**

[OAR Docket #14-978]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. Description of Organization

158:1-1-2. [AMENDED]

158:1-1-3. [AMENDED]

Subchapter 3. General Operation and Procedures

158:1-3-4. [AMENDED]

158:1-3-10. [AMENDED]

158:1-3-11. [AMENDED]

158:1-3-12. [AMENDED]

SUMMARY:

The proposed amendments to Subchapter 1 are for the purpose of clarifying that employees of the Construction Industries Board are unclassified employees.

The proposed amendments to 158:1-3-4 updates language to reflect current provisions of the Oklahoma Open Records Act. The amendments to 158:1-3-10, 158:1-3-11 and 158:1-3-12 are for the purpose of administering provisions of the Roofing Contractor Registration Act, as amended by House Bill 3184 which became effective November 1, 2014, as such relate to the Post-Military Service Occupation, Education and Credentialing Act, 59 O.S. § 4100.4, *et seq.*

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 858-627, 1000.4, 1000.5, 1002, 1032, 1681, 1850.3 and 1151.2a

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Construction Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant, 405-521-6550.

[OAR Docket #14-978; filed 11-25-14]

TITLE 158. CONSTRUCTION INDUSTRIES BOARD **CHAPTER 10. FINE SCHEDULE**

[OAR Docket #14-979]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 3. Administrative Fine Schedule

158:10-3-1. [AMENDED]

SUMMARY:

The proposed amendments are needed to establish the fines that may be assessed for violations of the Roofing Contractor Registration Act within the parameters established by the Act as amended by House Bill 3184 which became effective November 1, 2014

Notices of Rulemaking Intent

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 858-627, 1000.4, 1000.5, 1002, 1032, 1681, 1850.3 and 1151.2a

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Construction Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant, 405-521-6550.

[OAR Docket #14-979; filed 11-25-14]

TITLE 158. CONSTRUCTION INDUSTRIES BOARD CHAPTER 30. PLUMBING INDUSTRY REGULATIONS

[OAR Docket #14-980]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

158:30-1-2. [AMENDED]

158:30-1-3. [AMENDED]

158:30-1-4. [AMENDED]

Subchapter 3. Procedures of the Committee and Hearing Board

158:30-3-1. [AMENDED]

158:30-3-2. [AMENDED]

Subchapter 5. License Types, Bond Requirements, and Display of License Number and Firm Name

158:30-5-2. [AMENDED]

158:30-5-4. [AMENDED]

Subchapter 9. Examination Procedures, License and Registration Fees and Duration of Licenses

158:30-9-1. [AMENDED]

158:30-9-1.1. [NEW]

158:30-9-1.2. [NEW]

158:30-9-1.3. [NEW]

158:30-9-2. [AMENDED]

158:30-9-3. [AMENDED]

158:30-9-4. [AMENDED]

Subchapter 11. License Revocation or Suspension and Prohibited Acts

158:30-11-1. [AMENDED]

158:30-11-2. [AMENDED]

Subchapter 13. Procedure of the Variance and Appeals Boards, Plan Review Applications and Fees, Code Variance Applications and Fee, and Code Interpretation Appeals

158:30-13-1. [AMENDED]

158:30-13-4. [AMENDED]

SUMMARY:

Many of the proposed amendments are cleanup in nature and correct punctuation and grammar, correct or clarify references and citations, and delete duplicative/obsolete language. In addition, 158:30-1-2 amends the definition of "Applicant" as it relates to a person applying for review of plans and specifications or for a plumbing code variance to clarify that the applicant would be applying for a variance from the standard of installation as described in OAC 158:30-1-4 and adds a definition for "Oklahoma Uniform Building Code Commission" or "OUBCC"; 158:30-9-1 adds a provision requiring an apprentice registration to be on file with the Construction Industries Board for experience required to be eligible for the licensing exam, with the exception of experience lawfully obtained according to any applicable federal or state laws, and adds language which was adopted as an emergency rule which allows those who participate in approved plumbing educational programs that are less than 500 classroom hours to substitute at least a portion of the classroom hours completed for a portion of the experience required to test for licensing; 158:30-9-1.1, 158:30-9-1.2 and 158:30-9-1.3 are new sections for the purpose of clarifying that provisions in OAC 158:1 related to the Post-Military Service Occupation, Education and Credentialing Act, are applicable

to applicants for an initial plumbing license or renewal of a plumbing license; 158:30-9-4 adds a provision to clarify continuing education requirements for an individual who does not complete the required continuing education prior to the expiration of their plumbing license and removes restriction of limited individuals allowed to take online courses and adds provisions for all licensees to be able to receive continuing education credit for approved correspondence and online courses.

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 1000.4(A)(1) and 1002.

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Construction Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant, 405-521-6550.

[OAR Docket #14-980; filed 11-25-14]

**TITLE 158. CONSTRUCTION INDUSTRIES BOARD
CHAPTER 40. ELECTRICAL INDUSTRY REGULATIONS**

[OAR Docket #14-981]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 1. General Provisions
 - 158:40-1-2. AMENDED
 - 158:40-1-3. [AMENDED]
 - 158:40-1-4. [AMENDED]
- Subchapter 3. Procedures of the Committee and the Hearing Board
 - 158:40-3-1. [AMENDED]
 - 158:40-3-2. [AMENDED]
- Subchapter 5. Licensing Requirements, Display of License, and Firm Name, and Bond Requirements
 - 158:40-5-1. [AMENDED]
 - 158:40-5-2. [AMENDED]
 - 158:40-5-3. [AMENDED]
 - 158:40-5-4. [AMENDED]
 - 158:40-5-5. [AMENDED]
- Subchapter 7. License Classifications
 - 158:40-7-1. [AMENDED]
 - 158:40-7-2. [AMENDED]
 - 158:40-7-4. [AMENDED]
 - 158:40-7-5. [AMENDED]
- Subchapter 9. Examination Applications, Examinations and License and Registration Fees and Renewals
 - 158:40-9-1. [AMENDED]
 - 158:40-9-2.1. [NEW]
 - 158:40-9-2.2. [NEW]
 - 158:40-9-2.3. [NEW]
 - 158:40-9-3. [AMENDED]
 - 158:40-9-4. [AMENDED]
- Subchapter 11. License Revocation or Suspension and Prohibited Acts
 - 158:40-11-1. [AMENDED]
 - 158:40-11-2. [AMENDED]
- Subchapter 13. Procedures of the Variance and Appeals Board, Plan Review Applications and Filing Fees, Code Variance Applications and Filing Fee and Code Interpretation Appeals
 - 158:40-13-1. [AMENDED]

SUMMARY:

Many of the proposed amendments are cleanup in nature and correct spelling, punctuation and grammar, and correct or clarify references and citations. In addition, 158:40-9-2.1, 158:40-9-2.2 and 158:40-9-2.3 are new sections for the purpose of clarifying that provisions in OAC 158:1 related to the Post-Military Service Occupation, Education and credentialing Act, are applicable to applicants for an initial electrical license or renewal of an electrical license; and

Notices of Rulemaking Intent

158:40-9-4 adds a provision to clarify continuing education requirements for an individual who does not complete the required continuing education prior to the expiration of their electrical license.

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 1000.4(A)(1), 1000.5, and 1681.

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Construction Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant, 405-521-6550.

[OAR Docket #14-981; filed 11-25-14]

TITLE 158. CONSTRUCTION INDUSTRIES BOARD CHAPTER 50. MECHANICAL INDUSTRY REGULATIONS

[OAR Docket #14-982]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

158:50-1-2. [AMENDED]

158:50-1-3. [AMENDED]

158:50-1-4. [AMENDED]

Subchapter 3. Procedures of the Committee and the Hearing Board

158:50-3-1. [AMENDED]

Subchapter 5. License Types, Limitations of Licenses, Contractor Special Requirements and Display of License Number and Firm Name

158:50-5-3. [AMENDED]

Subchapter 9. Qualifications for Mechanical Licensure, License and Registration Fees, Duration of License, Mechanical License Application, and Apprentice Registration

158:50-9-1. [AMENDED]

158:50-9-1.1. [NEW]

158:50-9-1.2. [NEW]

158:50-9-1.3. [NEW]

158:50-9-2. [AMENDED]

158:50-9-3. [AMENDED]

158:50-9-5. [AMENDED]

158:50-9-6. [AMENDED]

158:50-9-7. [AMENDED]

Subchapter 11. License Revocation or Suspension and Prohibited Acts

158:50-11-1. [AMENDED]

158:50-11-2. [AMENDED]

158:50-11-3. [AMENDED]

Subchapter 13. Procedures of the Variance and Appeals Board, Plan Review Applications and Fees, Code Variance Applications and Fee, Code Interpretation Appeals

158:50-13-1. [AMENDED]

SUMMARY:

Many of the proposed amendments are cleanup in nature and correct spelling, punctuation and grammar, and correct or clarify references and citations. In addition, 158:50-1-2 clarifies/amends the definition for "Minor repairs and maintenance" and adds a definition for "Oklahoma Uniform Building Code Commission" or "OUBCC"; 158:50-9-1 clarifies experience that will be credited towards the experience requirement for licensing examination; 158:50-9-1.1, 158:50-9-1.2 and 158:50-9-1.3 are new sections for the purpose of clarifying that provisions in OAC 158:1 related to the Post-Military Service Occupation, Education and

Credentialing Act, are applicable to applicants for an initial mechanical license or renewal of a mechanical license; 158:50-9-7 adds a provision to clarify continuing education requirements for an individual who does not complete the required continuing education prior to the expiration of their mechanical license.

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 1000.4 and 1850.3.

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Constructions Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant, 405-521-6550.

[OAR Docket #14-982; filed 11-25-14]

**TITLE 158. CONSTRUCTION INDUSTRIES BOARD
CHAPTER 60. INSPECTORS REGULATIONS**

[OAR Docket #14-983]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 5. Categories and Classifications of Inspector Licenses, Qualifications for Inspector Licensure, License Requirements for Inspectors, Fees, Certification and Continuing Education for Inspectors, and Continuing Education Courses
- 158:60-5-2 [AMENDED]
- 158:60-5-2.1 [NEW]
- 158:60-5-2.2 [NEW]
- 158:60-5-2.3 [NEW]
- 158:60-5-5 [AMENDED]

SUMMARY:

The proposed amendments to 158:60-5-2 and 158:60-5-5 are cleanup in nature and correct spelling, grammar, and citation references.

The new sections are for the purpose of clarifying that the provisions in OAC 158:1 related to the Post-Military Service Occupation, Education and Credentialing Act, are applicable to applicants for an inspectors license or renewal of an inspectors license.

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 1000.4 and 1032.

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Constructions Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda

Notices of Rulemaking Intent

Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant, 405-521-6550.

[OAR Docket #14-983; filed 11-25-14]

TITLE 158. CONSTRUCTION INDUSTRIES BOARD

CHAPTER 70. HOME INSPECTION INDUSTRY REGULATIONS

[OAR Docket #14-984]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

158:70-1-2. [AMENDED]

158:70-1-3. [AMENDED]

Subchapter 3. Procedures of the Committee

158:70-3-1. [AMENDED]

Subchapter 9. Examination Applications, Examinations, Course Approval Requirements, Instructor Requirements, Continuing Education, Denied Application Appeal, Submission of Records, Substantial Compliance and Reciprocity

158:70-9-1.1. [NEW]

158:70-9-1.2. [NEW]

158:70-9-1.3. [NEW]

158:70-9-3. [AMENDED]

158:70-9-4. [AMENDED]

158:70-9-7. [AMENDED]

158:70-9-8. [AMENDED]

SUMMARY:

Many of the proposed amendments are cleanup in nature and correct formatting, spelling, punctuation and grammar, correct or clarify references and citations, and delete obsolete language. The new sections, 158:70-9-1.1, 158:70-9-1.2 and 158:70-9-1-3, are for the purpose of clarifying that provisions in OAC 158:1 related to the Post-Military Service Occupation, Education and credentialing Act, are applicable to applicants for an initial home inspector license or renewal of a home inspector license.

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 858-627 and 1000.4.

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Construction Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant, 405-521-6550.

[OAR Docket #14-984; filed 11-25-14]

TITLE 158. CONSTRUCTION INDUSTRIES BOARD

CHAPTER 85. ROOFING CONTRACTOR REGISTRATION REGULATIONS

[OAR Docket #14-985]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Chapter 85. Roofing Contractor Registration Regulations
[NEW]

SUMMARY:

The proposed rules are for the purpose of establishing regulations required for administering the Roofing Contractor Registration Act ("the Act") as amended by House Bill 3184 which became effective November 1, 2014. The amendments to the Act include the creation of the Committee of Roofing Examiners, the Roofing Hearing Board, and the Oklahoma State Roofing Installation Code Variance and Appeals Board; authority for the Construction Industries Board to enforce the Act; requirement of an examination endorsement and continuing education for commercial roofing registrations; change in expiration date from June 30 to birth month for roofing registrations, etc.

AUTHORITY:

Construction Industries Board; 59 O.S. §§1000.4 and 1151.2a

COMMENT PERIOD:

Written and oral comments will be accepted until 4:30 p.m. on January 14, 2015, at the following address: 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107. During the open public comment period, comments may be delivered during regular business hours or submitted via regular mail.

PUBLIC HEARING:

A Public Hearing is scheduled for 1:30 p.m. on Wednesday, January 21, 2015, at the monthly meeting of the Construction Industries Board which will be held in the Conference Room at 2401 NW 23rd Street, Suite 2F, Oklahoma City, OK 73107. Anyone who wishes to make comments regarding the proposed rules at the public hearing must sign in by 1:30 p.m.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Construction Industries Board requests that business entities affected by these proposed rules provide the Construction Industries Board, within the comment period set forth and described above, in dollar amounts if possible, the increase in the level of direct costs, such as administrative fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs that the business entity expects to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Linda Ruckman through the close of the comment period on January 14, 2015, at the address shown below for obtaining copies of the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules are available at the Construction Industries Board, 2401 NW 23rd Street, Ste. 2F, Oklahoma City, OK 73107, or online at www.cib.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and will be available beginning December 30, 2014, at the address listed above for obtaining copies of the proposed rules.

CONTACT PERSON:

Linda Ruckman, Board Secretary/Executive Assistant,
405-521-6550.

[OAR Docket #14-985; filed 11-25-14]

**TITLE 210. STATE DEPARTMENT OF
EDUCATION
CHAPTER 15. CURRICULUM AND
INSTRUCTION**

[OAR Docket #14-986]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 27. Reading Sufficiency Act
210:15-27-4. Criteria for high performing teacher [NEW]

SUMMARY:

The proposed rule at 210:15-27-4 outlines criteria for identifying a "high-performing teacher" for the purposes of the Reading Sufficiency Act at 70 O.S. § 1210.508A et seq. The Reading Sufficiency Act requires students who are retained under the Act to be provided with a high-performing teacher who can address the student's reading instruction needs, and the proposed rule establishes criteria for identifying teachers who satisfy the Act's requirements.

AUTHORITY:

State Board of Education; 70 O.S. § 3-104; 70 O.S. § 1210.508A et seq.

COMMENT PERIOD:

Written comments on the proposed rule(s) will be accepted from December 15, 2014 until 4:30 p.m., Friday, January 16, 2015.

Written comments in electronic form will be accepted during the open public comment period via email at rules@sde.ok.gov or by fax at (405) 521-6256. During the open public comment period, written comments may also be hand delivered to the agency during regular business hours or via regular mail to the individual at the address shown below under "Contact Person."

Oral comments may be submitted for the record at the public hearing at the time, date, and place shown below.

PUBLIC HEARING:

A public hearing is scheduled for 10:00 a.m. on Friday, January 16, 2015, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Persons wishing to speak must sign in at the door of the State Board Room prior to the start of the hearing. Time limitations may be imposed on oral presentations to ensure that all persons who desire to make oral comments will have an opportunity to do so.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

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COPIES OF PROPOSED RULES:

Copies of the proposed rule(s) may be obtained for review by the public from the Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Electronic copies of proposed rules are also available for review thirty (30) days prior to the hearing on the State Department of Education Legal Services website at: <http://ok.gov/sde/administrative-rules>

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a Rule Impact Statement will be prepared and available for review at the Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma on and after the date of publication of this Notice of Rulemaking Intent. A copy of the RIS will also be available on the State Department of Education Legal Services website at: <http://ok.gov/sde/administrative-rules>

CONTACT PERSON:

Lori Murphy, Assistant General Counsel, Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599. Telephone number: (405) 522-5260

[OAR Docket #14-986; filed 11-25-14]

TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 20. STAFF

[OAR Docket #14-987]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 9. Professional Standards: Teacher Education and Certification

210:20-9-96. Requirements for renewal or reissuance of certificates [AMENDED]

SUMMARY:

The proposed amendments to 210:20-9-96 provide that if a teaching or professional certificate has been expired for three or more years, the certificate holder applying for renewal must undergo a new criminal history record check under the terms of 70 O.S. § 5-142. The amendments are necessary to ensure that applicants who have committed disqualifying crimes in the time since their original certification are not re-certified.

AUTHORITY:

State Board of Education; 70 O.S. § 3-104; 70 O.S. § 5-142

COMMENT PERIOD:

Written comments on the proposed rule(s) will be accepted from December 15, 2014 until 4:30 p.m., Friday, January 16, 2015.

Written comments in electronic form will be accepted during the open public comment period via email at rules@sde.ok.gov or by fax at (405) 521-6256. During the open public comment period, written comments may also be hand delivered to the agency during regular business hours or via regular mail to the individual at the address shown below under "Contact Person."

Oral comments may be submitted for the record at the public hearing at the time, date, and place shown below.

PUBLIC HEARING:

A public hearing is scheduled for 10:00 a.m. on Friday, January 16, 2015, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Persons wishing to speak must sign in at the door of the State Board Room prior to the start of the hearing. Time limitations may be imposed on oral presentations to ensure that all persons who desire to make oral comments will have an opportunity to do so.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of the proposed rule(s) may be obtained for review by the public from the Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Electronic copies of proposed rules are also available for review thirty (30) days prior to the hearing on the State Department of Education Legal Services website at: <http://ok.gov/sde/administrative-rules>

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a Rule Impact Statement will be prepared and available for review at the Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma on and after the date of publication of this Notice of Rulemaking Intent. A copy of the RIS will also be available on the State Department of Education Legal Services website at: <http://ok.gov/sde/administrative-rules>

CONTACT PERSON:

Lori Murphy, Assistant General Counsel, Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599. Telephone number: (405) 522-5260

[OAR Docket #14-987; filed 11-25-14]

**TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 20. STAFF**

[OAR Docket #14-988]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 9. Professional Standards: Teacher Education and Certification

Part 9. Teacher Certification

210:20-9-99. National Board certification [REVOKED]

SUMMARY:

The revocation of 210:20-9-99 is necessary because its provisions are no longer in effect, due to amendments to 70 O.S. § 6-204.2 made by House Bill 1660 during the 2013 Regular Session. 70 O.S. § 6-204.2 now provides that teachers who attain National Board certification after June 30, 2013, will be compensated with a designated salary increment in the minimum teacher salary schedule, so the administrative rule at 210:20-9-99 no longer applies.

AUTHORITY:

State Board of Education; 70 O.S. § 3-104; 70 O.S. § 6-204.2

COMMENT PERIOD:

Written comments on the proposed rule(s) will be accepted from December 15, 2014 until 4:30 p.m., Friday, January 16, 2015.

Written comments in electronic form will be accepted during the open public comment period via email at rules@sde.ok.gov or by fax at (405) 521-6256. During the open public comment period, written comments may also be hand delivered to the agency during regular business hours or via regular mail to the individual at the address shown below under "Contact Person."

Oral comments may be submitted for the record at the public hearing at the time, date, and place shown below.

PUBLIC HEARING:

A public hearing is scheduled for 10:00 a.m. on Friday, January 16, 2015, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Persons wishing to speak must sign in at the door of the State Board Room prior to the start of the hearing. Time limitations may be imposed on oral presentations to ensure that all persons who desire to make oral comments will have an opportunity to do so.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of the proposed rule(s) may be obtained for review by the public from the Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Electronic copies of proposed rules are also

available for review thirty (30) days prior to the hearing on the State Department of Education Legal Services website at: <http://ok.gov/sde/administrative-rules>

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a Rule Impact Statement will be prepared and available for review at the Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma on and after the date of publication of this Notice of Rulemaking Intent. A copy of the RIS will also be available on the State Department of Education Legal Services website at: <http://ok.gov/sde/administrative-rules>

CONTACT PERSON:

Lori Murphy, Assistant General Counsel, Office of Legal Services, State Department of Education, Room 1-17, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599. Telephone number: (405) 522-5260

[OAR Docket #14-988; filed 11-25-14]

**TITLE 218. OFFICE OF EDUCATIONAL QUALITY AND ACCOUNTABILITY
CHAPTER 1. ADMINISTRATIVE OPERATIONS**

[OAR Docket #14-975]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Chapter 1. Administrative Operations [NEW]

SUMMARY:

The proposed rules outline the administrative duties and responsibilities of the Office of Educational Quality and Accountability and its Executive Director.

AUTHORITY:

Commission for Educational Quality and Accountability; 70 O.S. Supp. 2012, §3-116 et seq.

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 4:30 p.m. on January 20, 2015 at the following address: Office for Educational Quality and Accountability, 840 Research Parkway, Suite 455, Oklahoma City, OK 73104.

PUBLIC HEARING:

A public hearing starting at 9:00 a.m. on Tuesday, January 20, 2015 in the 4th floor Board Room, 840 Research Parkway, Suite 455, Oklahoma City, OK, 73104.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency within the comment period, with information, in dollar amounts if possible, about the increase in the level of direct costs, indirect costs, or other

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costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Dr. Sherry Labyer, at the above address, before the close of the comment period.

COPIES OF PROPOSED RULES:

Copies of the proposed rule may be obtained from the Office of Educational Quality and Accountability, 840 Research Parkway, Suite 455, Oklahoma City, OK 73104.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303 (D), a rule impact statement will be prepared and may be obtained from the Office of Educational Quality and Accountability at the above address beginning on December 30, 2014.

CONTACT PERSON:

Dr. Sherry Labyer, Executive Director (405) 522-5399

[OAR Docket #14-975; filed 11-24-14]

TITLE 218. OFFICE OF EDUCATIONAL QUALITY AND ACCOUNTABILITY **CHAPTER 10. EDUCATIONAL QUALITY**

[OAR Docket #14-976]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Educator Preparation Program Accreditation [NEW]

Subchapter 7. Educator Assessment [NEW]

Subchapter 9. Education Leadership Oklahoma [NEW]

Appendix A. Competency Exam Requirements by Certification Areas [NEW]

SUMMARY:

The rules reflect the Commission for Educational Quality and Accountability statutory responsibilities for accrediting educator preparation programs, assessing educator candidates, and Education Leadership Oklahoma.

AUTHORITY:

Commission for Educational Quality and Accountability; 70 O.S. Supp. 2012, §3-116 et seq.

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 4:30 p.m. on January 20, 2015 at the following address: Office for Educational Quality and Accountability, 840 Research Parkway, Suite 455, Oklahoma City, OK 73104.

PUBLIC HEARING:

A public hearing starting at 9:00 a.m. on Tuesday, January 20, 2015 in the 4th floor Board Room, 840 Research Parkway, Suite 455, Oklahoma City, OK, 73104.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency within the comment period,

with information, in dollar amounts if possible, about the increase in the level of direct costs, indirect costs, or other costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Dr. Sherry Labyer, at the above address, before the close of the comment period.

COPIES OF PROPOSED RULES:

Copies of the proposed rule may be obtained from the Office of Educational Quality and Accountability, 840 Research Parkway, Suite 455, Oklahoma City, OK 73104.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303 (D), a rule impact statement will be prepared and may be obtained from the Office of Educational Quality and Accountability at the above address beginning on December 30, 2014.

CONTACT PERSON:

Dr. Sherry Labyer, Executive Director (405) 522-5399

[OAR Docket #14-976; filed 11-24-14]

TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES **CHAPTER 15. ACCESSIBILITY OF INFORMATION TECHNOLOGY**

[OAR Docket #14-967]

INTENDED RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Chapter 15. Accessibility of Information Technology [AMENDED]

SUMMARY:

It is proposed that the rules and regulations be amended to promote and enhance effective operation of the Office of Management and Enterprise Services. The effect of the amended rules is to remove inaccurate and redundant verbiage and to clarify and simplify.

AUTHORITY:

62 O.S. §34.28. Office of Management and Enterprise Services.

COMMENT PERIOD:

Written comments may be made from this date until January 15, 2015. Comments should be filed in the office of Gary Goff, Deputy General Counsel, Office of Management and Enterprise Services Employees Group Insurance Division, located at 3545 NW 58th Street, Suite 110, Oklahoma City, Oklahoma 73112.

PUBLIC HEARING:

8:00 am, January 15, 2015, in the 5th Floor Board Room of the Office of Management and Enterprise Services Employees Group Insurance Division, 3545 NW 58th Street, Oklahoma City, Oklahoma. Each person will be allowed a maximum of 5 minutes to speak and must sign in at the door.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Gary Goff, Deputy General Counsel
Office of Management and Enterprise Services
Employees Group Insurance Division
3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112

RULE IMPACT STATEMENT:

This agency has issued a Rule Impact Statement which may be obtained for review by contacting Gary Goff of the Office of Management and Enterprise Services Employees Group Insurance Division.

CONTACT PERSON:

Gary Goff, Deputy General Counsel, (405) 717-8744

[OAR Docket #14-967; filed 11-20-14]

**TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
CHAPTER 25. MERIT SYSTEM OF PERSONNEL ADMINISTRATION RULES**

[OAR Docket #14-968]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Chapter 25. Merit System of Personnel Administration Rules [AMENDED]

SUMMARY:

The rules and regulations are necessary to promote and enhance effective operation of the State's work force. It is proposed that the rules and regulations be amended. The effect of the amended rules is to comply with repealed or amended statutes; add a more comprehensive and user friendly Appendix B- Schedule of Annual and Sick Leave Accumulation Limits and Yearly Accruals; allow State agencies more flexibility concerning personnel policies, practice and procedures, including greater flexibility in hiring practices and how pay adjustments are implemented; remove burdensome and unnecessary reporting requirements; simplify and eliminate unnecessary language; remove references to the Office of Personnel Management; and remove references to Title 530.

AUTHORITY:

Office of Management and Enterprise Services Human Capital Management Division. 74 O.S. Section 840-1.6A; 74 O.S. Section 840-2.17; 74 O.S. Section 840-2.9; 74 O.S. Section 840-2.20; 74 O.S. Section 840-3.2; 74 O.S. Section 840-3.5; 74 O.S. 840-4.3; 74 O.S. Section 840-4.6; 74 O.S. Section 840-4.12; 740 O.S. Section 840-4.13; 74 O.S. Section 840-4.17.

COMMENT PERIOD:

Written comments may be made from this date until January 22, 2015. Comments should be filed in the office of

Matt Stewart, Deputy General Counsel, Office of Management and Enterprise Services Human Capital Management Division, located at 2101 N. Lincoln Blvd., suite G-80, Oklahoma City, Oklahoma 73105.

PUBLIC HEARING:

10:30 am, January 22, 2015, in the HCM Training Room located in the Jim Thorpe Building (basement), 2101 N. Lincoln Blvd., Suite G-80, Oklahoma City, Oklahoma 73105. Each person will be allowed a maximum of 5 minutes to speak and must sign in at the door.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Matt Stewart, Deputy General Counsel
Office of Management and Enterprise Services
Human Capital Management Division
2101 N. Lincoln Blvd., Suite G-80
Oklahoma City, OK 73105

RULE IMPACT STATEMENT:

This agency has issued a Rule Impact Statement which may be obtained for review by contacting Matt Stewart of the Office of Management and Enterprise Services Human Capital Management Division.

CONTACT PERSON:

Matt Stewart, Deputy General Counsel, (405) 522-0663

[OAR Docket #14-968; filed 11-20-14]

**TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
CHAPTER 45. EMPLOYEES GROUP INSURANCE DIVISION - ADMINISTRATIVE AND GENERAL PROVISIONS**

[OAR Docket #14-969]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Chapter 45. Employees Group Insurance Division - Administrative and General Provisions [AMENDED]

SUMMARY:

The Rule is being changed to reflect a more efficient and less costly method of providing written notice of hearings as required by law.

AUTHORITY:

74 O.S. Section 1304; 74 O.S. Section 1306. Office of Management and Enterprise Services Employees Group Insurance Division.

COMMENT PERIOD:

Written comments may be made from this date until January 15, 2015. Comments should be filed in the office of Gary Goff, Deputy General Counsel, Office of Management and Enterprise Services Employees Group Insurance Division,

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located at 3545 NW 58th Street, Suite 110, Oklahoma City, Oklahoma 73112.

PUBLIC HEARING:

8:00 am, January 15, 2015, in the 5th Floor Board Room of the Office of Management and Enterprise Services Employees Group Insurance Division, 3545 NW 58th Street, Oklahoma City, Oklahoma. Each person will be allowed a maximum of 5 minutes to speak and must sign in at the door.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Gary Goff, Deputy General Counsel
Office of Management and Enterprise Services
Employees Group Insurance Division
3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112

RULE IMPACT STATEMENT:

This agency has issued a Rule Impact Statement which may be obtained for review by contacting Gary Goff of the Office of Management and Enterprise Services Employees Group Insurance Division.

CONTACT PERSON:

Gary Goff, Deputy General Counsel, (405) 717-8744

[OAR Docket #14-969; filed 11-20-14]

TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES CHAPTER 50. EMPLOYEES GROUP INSURANCE DIVISION - HEALTH, DENTAL, VISION AND LIFE PLANS

[OAR Docket #14-970]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Chapter 50. Employees Group Insurance Division - Health, Dental, Vision and Life Plans [AMENDED]

SUMMARY:

The Rule is being changed to remove redundant and inaccurate verbiage.

AUTHORITY:

74 O.S. Section 1304; 74 O.S. Section 1306. Office of Management and Enterprise Services Employees Group Insurance Division.

COMMENT PERIOD:

Written comments may be made from this date until January 15, 2015. Comments should be filed in the office of Gary Goff, Deputy General Counsel, Office of Management and Enterprise Services Employees Group Insurance Division, located at 3545 NW 58th Street, Suite 110, Oklahoma City, Oklahoma 73112.

PUBLIC HEARING:

8:00 am, January 15, 2015, in the 5th Floor Board Room of the Office of Management and Enterprise Services Employees Group Insurance Division, 3545 NW 58th Street, Oklahoma City, Oklahoma. Each person will be allowed a maximum of 5 minutes to speak and must sign in at the door.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Gary Goff, Deputy General Counsel
Office of Management and Enterprise Services
Employees Group Insurance Division
3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112

RULE IMPACT STATEMENT:

This agency has issued a Rule Impact Statement which may be obtained for review by contacting Gary Goff of the Office of Management and Enterprise Services Employees Group Insurance Division.

CONTACT PERSON:

Gary Goff, Deputy General Counsel, (405) 717-8744

[OAR Docket #14-970; filed 11-20-14]

TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES CHAPTER 55. EMPLOYEES GROUP INSURANCE DIVISION - THE DISABILITY PLAN

[OAR Docket #14-971]

INTENDED RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Chapter 55. Employees Group Insurance Division - The Disability Plan [AMENDED]

SUMMARY:

The Rule is being changed to correct a scrivener error.

AUTHORITY:

74 O.S. Section 1304; 74 O.S. Section 1306; 74 O.S. Section 1332 Office of Management and Enterprise Services Employees Group Insurance Division.

COMMENT PERIOD:

Written comments may be made from this date until January 15, 2015. Comments should be filed in the office of Gary Goff, Deputy General Counsel, Office of Management and Enterprise Services Employees Group Insurance Division, located at 3545 NW 58th Street, Suite 110, Oklahoma City, Oklahoma 73112.

PUBLIC HEARING:

8:00 am, January 15, 2015, in the 5th Floor Board Room of the Office of Management and Enterprise Services Employees Group Insurance Division, 3545 NW 58th Street, Oklahoma

City, Oklahoma. Each person will be allowed a maximum of 5 minutes to speak and must sign in at the door.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Gary Goff, Deputy General Counsel
Office of Management and Enterprise Services
Employees Group Insurance Division
3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112

RULE IMPACT STATEMENT:

This agency has issued a Rule Impact Statement which may be obtained for review by contacting Gary Goff of the Office of Management and Enterprise Services Employees Group Insurance Division.

CONTACT PERSON:

Gary Goff, Deputy General Counsel, (405) 717-8744

[OAR Docket #14-971; filed 11-20-14]

**TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
CHAPTER 60. FACILITIES MANAGEMENT**

[OAR Docket #14-972]

RULEMAKING ACTION:

Notice of proposed permanent rulemaking.

PROPOSED RULES:

Subchapter 3. Use of Public Areas of Capitol and Plazas
260:60-3-2. Capitol access, operating hours and access requirements [AMENDED]

SUMMARY:

The purpose of this proposed rulemaking action is to enhance safety and security with the State Capitol Building by prohibiting the wearing of masks or hoods that conceal the identify of the wearer. Other changes may be made to correct citations and scrivener's errors, to improve the clarity of the rules, to modernize language, and to remove redundancies.

AUTHORITY:

62 O.S. §34.6; Director of the Office of Management and Enterprise Services.

COMMENT PERIOD:

Persons may submit written and oral comments to Kimberlee Williams at Kimberlee.Williams@omes.ok.gov during the period from December 15, 2014 through January 16, 2015.

PUBLIC HEARING:

A public hearing has been scheduled for 9:00 a.m. January 15, 2015 at the offices of the Division of Capital Assets Management, 2401 N. Lincoln Blvd (Will Rogers Building), Conference Room 206-8, Oklahoma City, OK.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

This proposed rulemaking action is not intended to impose costs on business entities.

COPIES OF PROPOSED RULES:

Copies of the proposed rule may be obtained by written request directed to Kimberlee.Williams@omes.ok.gov.

RULE IMPACT STATEMENT:

As required by 75 O.S. §303(D), a rule impact statement will be available beginning December 15, 2014.

CONTACT PERSON:

Kimberlee Williams, (405) 522-3615 or Kimberlee.Williams@omes.ok.gov.

[OAR Docket #14-972; filed 11-20-14]

**TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
CHAPTER 115. PROCUREMENT**

[OAR Docket #14-973]

RULEMAKING ACTION:

Notice of proposed permanent rulemaking.

PROPOSED RULES:

Chapter 115. Procurement [AMENDED]

SUMMARY:

The purpose of this proposed rulemaking action is to make the rules consistent with statutory changes made during the 2014 legislative session, to streamline processes, to correct citations and scrivener's errors, and to improve the clarity of the rules. Changes may also be made to reduce administrative burdens on state agencies where possible.

AUTHORITY:

74 O.S. §85.5; Director of the Office of Management and Enterprise Services

COMMENT PERIOD:

Persons may submit written and oral comments to Kimberlee Williams at Kimberlee.Williams@omes.ok.gov during the period from December 15, 2014 through January 16, 2015.

PUBLIC HEARING:

A public hearing has been scheduled for 1:30 p.m. January 15, 2015 at the offices of the Division of Capital Assets Management, 2401 N. Lincoln Blvd (Will Rogers Building), Conference Room 206-8, Oklahoma City, OK.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

This proposed rulemaking action is not intended to impose costs on business entities.

COPIES OF PROPOSED RULES:

Copies of the proposed rule may be obtained by written request directed to Kimberlee.Williams@omes.ok.gov.

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RULE IMPACT STATEMENT:

As required by 75 O.S. §303(D), a rule impact statement will be available beginning December 15, 2014.

CONTACT PERSON:

Kimberlee Williams, (405) 522-3615 or
Kimberlee.Williams@omes.ok.gov.

[OAR Docket #14-973; filed 11-20-14]

TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES CHAPTER 120. STATE USE COMMITTEE OPERATIONAL PROCEDURES

[OAR Docket #14-974]

RULEMAKING ACTION:

Notice of proposed permanent rulemaking.

PROPOSED RULES:

260:120-1-2. Definitions [AMENDED]

260:120-1-4. Determination of fair market price
[AMENDED]

SUMMARY:

The purpose of this proposed rulemaking action is to correct citations and scrivener's errors, to improve the clarity of the rules, to modernize language, and to remove redundancies.

AUTHORITY:

62 O.S. §34.6; Director of the Office of Management and Enterprise Services

COMMENT PERIOD:

Persons may submit written and oral comments to Kimberlee Williams at Kimberlee.Williams@omes.ok.gov during the period from December 15, 2014 through January 16, 2015.

PUBLIC HEARING:

A public hearing has been scheduled for 3:00 p.m. January 15, 2015 at the offices of the Division of Capital Assets Management, 2401 N. Lincoln Blvd (Will Rogers Building), Conference Room 206-8, Oklahoma City, OK.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

This proposed rulemaking action is not intended to impose costs on business entities.

COPIES OF PROPOSED RULES:

Copies of the proposed rule may be obtained by written request directed to Kimberlee.Williams@omes.ok.gov.

RULE IMPACT STATEMENT:

As required by 75 O.S. §303(D), a rule impact statement will be available beginning December 15, 2014.

CONTACT PERSON:

Kimberlee Williams, (405) 522-3615 or
Kimberlee.Williams@omes.ok.gov.

[OAR Docket #14-974; filed 11-20-14]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 25. SOONERCARE CHOICE

[OAR Docket #14-992]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 7. SoonerCare

Part 3. Enrollment Criteria

317:25-7-13 [AMENDED]

Part 5. Enrollment Process

317:25-7-28 [AMENDED]

(Reference APA WF # 14-09)

SUMMARY:

SoonerCare Choice enrollment ineligibility rules are amended to include making individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice; individuals in the former foster care eligibility group are also ineligible for SoonerCare Choice. Additionally, members who are currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be disenrolled from the program. Children who are known to be in OKDHS custody are now eligible to participate in SoonerCare Choice.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 1115 Demonstration Project No. 11-W00048/6

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-992; filed 11-25-14]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE**

[OAR Docket #14-1008]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 7. Soonercare
Part 1. General Provisions
317:25-7-7 [AMENDED]
(Reference APA WF # 14-41)

SUMMARY:

Policy is revised to convey that electronic referrals will eliminate the need of paper referral documentation within members' medical records.

AUTHORITY:

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

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1008; filed 11-25-14]

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

[OAR Docket #14-989]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties
Part 35. Rural Health Clinics
317:30-5-355.1 [AMENDED]
317:30-5-356 [AMENDED]
317:30-5-357 [AMENDED]
317:30-5-361 [AMENDED]
Part 75. Federally Qualified Health Centers
317:30-5-664.3 [AMENDED]
317:30-5-664.4 [REVOKED]
317:30-5-664.12 [AMENDED]
(Reference APA WF # 14-02)

SUMMARY:

Rules are revised to limit encounters within Federal Qualified Health Centers (FQHC) and Rural Health Clinic Services (RHC) to one encounter per member per day as well as limit encounters to a total of four visits per member per month. This change in procedure regarding encounters in FQHCs and RHCs is needed in order to reduce overall costs of the Medicaid program.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.20; CFR 447.371; 42 CFR 440.365

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

Notices of Rulemaking Intent

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-989; filed 11-25-14]

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

[OAR Docket #14-990]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties

Part 3. Hospitals

317:30-5-56 [AMENDED]

(Reference APA WF # 14-04)

SUMMARY:

Rules are amended to reduce/deny payment for preventable readmissions that occur within 30 days from discharge. The current policy reviews readmissions occurring within 15 days of prior acute care admissions or a related condition to determine medical necessity and appropriateness of care. If it is determined either or both admissions may be inappropriate, payment for either or both admissions may be denied. This change in policy regarding readmissions is needed in order to reduce overall costs of the Medicaid program.

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 412.50 through 42 CFR 412.154

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-990; filed 11-25-14]

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

[OAR Docket #14-991]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 3. General Provider Policies

Part 3. General Medical Program Information

317:30-3-57 [AMENDED]

Part 4. Early and Periodic Screening, Diagnosis and

Treatment (EPSDT) Program/Child Health Services

317:30-3-65.7 [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 45. Optometrists

317:30-5-432.1 [AMENDED]

(Reference APA WF # 14-08)

SUMMARY:

Rules are amended to limit the number of payment for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary. These changes are needed in order to reduce the overall costs of the Medicaid program.

AUTHORITY:

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

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-991; filed 11-25-14]

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

[OAR Docket #14-993]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties

Part 79. Dentists

317:30-5-696 [AMENDED]

317:30-5-698 [AMENDED]

317:30-5-699 [AMENDED]

(Reference APA WF # 14-11)

SUMMARY:

Dental rules are revised to eliminate the perinatal dental benefit.

AUTHORITY:

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

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-993; filed 11-25-14]

Notices of Rulemaking Intent

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

[OAR Docket #14-994]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-126 [AMENDED]

(Reference APA WF # 14-12)

SUMMARY:

Rules are revoked to eliminate payment for hospital leave to nursing facilities and ICF/IIDs. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. This change in procedure regarding payment to nursing facilities is needed in order to reduce overall costs of the Medicaid program.

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 483.12

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development,
(405)522-7153.

[OAR Docket #14-994; filed 11-25-14]

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

[OAR Docket #14-995]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties

Part 21. Outpatient Behavioral Health Agency Services

317:30-5-241.2 [AMENDED]

317:30-5-241.3 [AMENDED]

(Reference APA WF # 14-13)

SUMMARY:

Outpatient behavioral health rules are amended to add additional eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; are residing in residential care facilities; or are receiving services through a specialty court program. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist, or psychiatrist and determined to be "at risk". Narrowing the eligibility criteria for PSR services comports with the Federal definition of rehabilitative services found in 42 CFR 440.130(d) which defines them as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts... for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level."

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.130; 42 CFR 440.230

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-995; filed 11-25-14]

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

[OAR Docket #14-997]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 21. Outpatient Behavioral Health Agency Services
317:30-5-241 [AMENDED]
- Part 25. Psychologists
317:30-5-276 [AMENDED]
- Part 26. Licensed Behavioral Health Providers
317:30-5-281 [AMENDED]

(Reference APA WF # 14-15)

SUMMARY:

Rules are revised to limit the number of hours that outpatient behavioral health rendering providers can be reimbursed to 35 hours per week.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.230

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-997; filed 11-25-14]

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

[OAR Docket #14-998]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 22. Health Homes [NEW]
317:30-5-250 [NEW]
317:30-5-251 [NEW]
317:30-5-252 [NEW]
317:30-5-253 [NEW]
317:30-5-254 [NEW]

(Reference APA WF # 14-16)

SUMMARY:

Rules are added to create coverage guidelines for Health Homes. Health Homes are created to promote enhanced

Notices of Rulemaking Intent

integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 2703 of the Affordable Care Act (Public Law 111-148); Section 1945 of Social Security Act

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-998; filed 11-25-14]

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

[OAR Docket #14-1001]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties
Part 64. Clinic Services
317:30-5-579 [NEW]

(Reference APA WF # 14-24)

SUMMARY:

Policy is added to outline special provisions and contracting requirements for providers participating in the 340B Drug Discount Program per federal regulation.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 thru 5016 of Title 63 of Oklahoma Statutes; 42 U.S.C.256b; and Section 340B Public Health Act

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1001; filed 11-25-14]

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

[OAR Docket #14-1002]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-134 [AMENDED]

(Reference APA WF # 14-26)

SUMMARY:

The Agency's nurse aide training program rules are revised to specify that payment for training will be directly reimbursed to qualified nurse aides on a quarterly basis for every quarter the individual is employed in a nursing facility. Rules are also revised to establish a maximum rate for reimbursement for nurse aides who have paid for training and competency examination fees.

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 483.152

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1002; filed 11-25-14]

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

[OAR Docket #14-1003]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties

Part 62. Private Duty Nursing

317:30-5-559 [AMENDED]

317:30-5-560 [AMENDED]

317:30-5-560.1 [AMENDED]

(Reference APA WF # 14-27)

SUMMARY:

Private Duty Nursing (PDN) rules are revised to reflect an OHCA physician will be responsible for utilizing the acuity grid to help make a determination for medical necessity. The Care Management nurses' responsibility will be to gather, summarize, and present the individual cases to the physician.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.80

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

Notices of Rulemaking Intent

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1003; filed 11-25-14]

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

[OAR Docket #14-1004]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-14 [AMENDED]

(Reference APA WF # 14-29A)

SUMMARY:

Policy is revised to clean up language regarding the pharmacy lock-in program. Current policy locks members in to one primary physician and/or on pharmacy. Policy is revised to allow members to be locked in to an approved prescriber rather than primary care physician and pharmacy.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 thru 5016 of Title 63 of Oklahoma Statutes; 42 CFR 431.54; 42 CFR 440.230

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular

business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1004; filed 11-25-14]

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

[OAR Docket #14-1006]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
317:30-5-211.7 [AMENDED]

(Reference APA WF # 14-35)

SUMMARY:

Rules regarding SoonerCare member's freedom of choice to select their provider of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are amended to state that providers must inform members of this right when filling or ordering DMEPOS.

AUTHORITY:

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

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1006; filed 11-25-14]

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

[OAR Docket #14-1007]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 6. Inpatient Psychiatric Hospitals
- 317:30-5-95.4 [AMENDED]
- 317:30-5-95.14 [AMENDED]
- 317:30-5-95.33 [AMENDED]
- (Reference APA WF # 14-38)

SUMMARY:

Inpatient psychiatric hospital policy is revised to clarify that the member's signature on the Individual Plan of Care is required at the time of completion.

AUTHORITY:

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

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1007; filed 11-25-14]

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

[OAR Docket #14-1009]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 6. Inpatient Psychiatric Hospitals
- 317:30-5-95.6 [AMENDED]
- 317:30-5-95.16 [AMENDED]
- 317:30-5-95.37 [AMENDED]
- (Reference APA WF # 14-42)

SUMMARY:

Policy is revised to change the timeframe in which a History and Physical (H&P) should be completed in order to comply with federal regulation. The H&P will be completed within 24 hours after admission into an inpatient psychiatric hospital.

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 482.22

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority,

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4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1009; filed 11-25-14]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

[OAR Docket #14-999]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Eligibility and Countable Income

Part 5. Countable Income and Resources

317:35-5-41.2 [AMENDED]

317:35-5-41.3 [AMENDED]

317:35-5-42 [AMENDED]

(Reference APA WF #14-17)

SUMMARY:

SoonerCare rules regarding enrollment eligibility for individuals categorically related to the Aged, Blind, and Disabled population are aligned to match that of the Social

Security Administration's rules for determining SSI eligibility. Policy changes include adding new language regarding the Asset Verification System to check the income or resources of ABD applicants held at fiscal institutions, updating how resources are counted towards the maximum resource limit, exempting the value of one automobile regardless of its value from the maximum resource limit, expanding the income disregards list, and disregarding \$20 unearned of income. State Plan changes include removing references of eligibility criteria that is more restrictive than SSI.

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(f) of the Social Security Act; 42 CFR §435.120; 1915(c) Home and Community Based Services Waiver

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-999; filed 11-25-14]

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

[OAR Docket #14-1000]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 15. Personal Care Services
- 317:35-15-1 [AMENDED]
- 317:35-15-2 [AMENDED]
- 317:35-15-3 [AMENDED]
- 317:35-15-4 [AMENDED]
- 317:35-15-7 [AMENDED]
- 317:35-15-8 [AMENDED]
- 317:35-15-8.1 [AMENDED]
- 317:35-15-9 [AMENDED]
- 317:35-15-10 [AMENDED]
- 317:35-15-13.1 [AMENDED]
- 317:35-15-13.2 [AMENDED]
- 317:35-15-14 [AMENDED]
- 317:35-15-15 [AMENDED]

(Reference APA WF # 14-18)

SUMMARY:

Rules for the State Plan Personal Care services are amended to match current processes and procedures that are currently in place at OKDHS. Changes include policy clean up to remove unnecessary or redundant language regarding service settings and the criteria for persons eligible to serve as Personal Care Assistants.

AUTHORITY:

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

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to

Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development, (405)522-7153.

[OAR Docket #14-1000; filed 11-25-14]

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

[OAR Docket #14-1005]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 3. Coverage and Exclusions

317:35-3-1 [AMENDED]

(Reference APA WF # 14-29B)

SUMMARY:

Policy is revised to clean up language regarding the pharmacy lock-in program. Current policy locks members in to one primary physician and/or on pharmacy. Policy is revised to allow members to be locked in to an approved prescriber rather than primary care physician and pharmacy.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 thru 5016 of Title 63 of Oklahoma Statutes; 42 CFR 431.54; 42 CFR 440.230

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping,

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equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development,
(405)522-7153.

[OAR Docket #14-1005; filed 11-25-14]

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

[OAR Docket #14-996]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. Medically Fragile Waiver Services
317:50-1-14 [AMENDED]

Subchapter 3. My Life, My Choice
317:50-3-14 [AMENDED]

Subchapter 5. Sooner Seniors
317:50-5-14 [AMENDED]

(Reference APA WF # 14-14)

SUMMARY:

Policy is revised to include all 1915(c) waiver programs to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. The regulation states providers of Home and Community Based Services (HCBS) for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person centered service plan.

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, 42 CFR 441.301

COMMENT PERIOD:

Written and oral comments will be accepted December 16, 2014, through January 15, 2015, during regular business hours by contacting Tywanda Cox, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105, Telephone 405-522-7153.

PUBLIC HEARING:

A public hearing is scheduled for Thursday, January 15, 2015, at 9:00 a.m., at the Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma, 73105.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Tywanda Cox, at the above address, before the close of the comment period on January 15, 2015.

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

CONTACT PERSON:

Tywanda Cox, Director, Policy Development,
(405)522-7153.

[OAR Docket #14-996; filed 11-25-14]

TITLE 428. LONG-RANGE CAPITAL PLANNING COMMISSION CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #14-965]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

428:1-1-1. Purpose and scope [AMENDED]

428:1-1-2. Official office [AMENDED]

428:1-1-4. Notice of meetings [AMENDED]

428:1-1-5. Agenda items [AMENDED]

428:1-1-6. Open records [AMENDED]

SUMMARY:

The purpose of this proposed rulemaking action is to update terminology, make the rules consistent with statutory changes, correct scrivener's errors, and improve clarity.

AUTHORITY:

62 O.S. §901; Long-Range Capital Planning Commission

COMMENT PERIOD:

Persons may submit written and oral comments to Kimberlee Williams at Kimberlee.Williams@omes.ok.gov

during the period from December 15, 2014 through January 16, 2015.

PUBLIC HEARING:

A public hearing has been scheduled for 10:00 a.m., January 15, 2015 at the offices of the Division of Capital Assets Management, 2401 N. Lincoln Blvd (Will Rogers Building), Conference Room 206-8, Oklahoma City, OK.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

This proposed rulemaking action is not intended to impose costs on business entities.

COPIES OF PROPOSED RULES:

Copies of the proposed rule may be obtained by written request directed to Kimberlee.Williams@omes.ok.gov.

RULE IMPACT STATEMENT:

As required by 75 O.S. §303(D), a rule impact statement will be available beginning December 15, 2014.

CONTACT PERSON:

Kimberlee Williams, (405) 522-3615 or Kimberlee.Williams@omes.ok.gov.

[OAR Docket #14-965; filed 11-20-14]

**TITLE 428. LONG-RANGE CAPITAL PLANNING COMMISSION
CHAPTER 10. ADMINISTRATION OF THE STATE CAPITAL IMPROVEMENT PLANNING ACT**

[OAR Docket #14-966]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

428:10-1-1. Purpose and scope [AMENDED]

SUMMARY:

The purpose of this proposed rulemaking action is to update terminology, make the rules consistent with statutory changes, correct scrivener's errors and improve clarity.

AUTHORITY:

62 O.S. §901; Long-Range Capital Planning Commission.

COMMENT PERIOD:

Persons may submit written and oral comments to Kimberlee Williams at Kimberlee.Williams@omes.ok.gov during the period from December 15, 2014 through January 16, 2015.

PUBLIC HEARING:

A public hearing has been scheduled for 10:00 a.m., January 15, 2015 at the offices of the Division of Capital Assets Management, 2401 N. Lincoln Blvd (Will Rogers Building), Conference Room 206-8, Oklahoma City, OK.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

This proposed rulemaking action is not intended to impose costs on business entities.

COPIES OF PROPOSED RULES:

Copies of the proposed rule may be obtained by written request directed to Kimberlee.Williams@omes.ok.gov.

RULE IMPACT STATEMENT:

As required by 75 O.S. §303(D), a rule impact statement will be available beginning December 15, 2014.

CONTACT PERSON:

Kimberlee Williams, (405) 522-3615 or Kimberlee.Williams@omes.ok.gov.

[OAR Docket #14-966; filed 11-20-14]

Submissions to Governor and Legislature

Within 10 calendar days after adoption by an agency of proposed PERMANENT rules, the agency must submit the rules to the Governor and the Legislature. A "statement" of such submission must subsequently be published by the agency in the *Register*.
For additional information on submissions to the Governor/Legislature, see 75 O.S., Section 303.1 and 308.

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

[OAR Docket #14-963]

RULEMAKING ACTION:

Submission to Governor and Legislature

RULES:

Subchapter 7. Regulation of Physician and Surgeon Practice

435:10-7-12. Establishing a physician/patient relationship; exceptions [AMENDED]

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:

November 14, 2014

[OAR Docket #14-963; filed 11-18-14]

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

[OAR Docket #14-964]

RULEMAKING ACTION:

Submission to Governor and Legislature

RULES:

Subchapter 11. Temporary and Special Licensure

435:10-11-3. Procedure for special licensure [AMENDED]

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:

November 14, 2014

[OAR Docket #14-964; filed 11-18-14]

Emergency Adoptions

"If an agency finds that a rule is necessary as an emergency measure, the rule may be promulgated" if the Governor approves the rules after determining "that the rule is necessary as an emergency measure to do any of the following:

- a. protect the public health, safety or welfare,
- b. comply with deadlines in amendments to an agency's governing law or federal programs,
- c. avoid violation of federal law or regulation or other state law,
- d. avoid imminent reduction to the agency's budget, or
- e. avoid serious prejudice to the public interest." [75 O.S., Section 253(A)]

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

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

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

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

[OAR Docket #14-958]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Agency Services
317:30-5-241. [AMENDED]
Part 25. Psychologists
317:30-5-276. [AMENDED]
Part 26. Licensed Behavioral Health Providers
317:30-5-281. [AMENDED]
(Reference APA WF # 14-15)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.230

ADOPTION:

September 11, 2014

APPROVED BY GOVERNOR:

November 3, 2014

EFFECTIVE:

Immediately upon governor's approval or October 1, 2014, whichever is later

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual provider and specialties guidelines. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.

ANALYSIS:

Rules are revised to limit the number of hours that outpatient behavioral health rendering providers can be reimbursed to 35 hours per week.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR OCTOBER 1, 2014, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and service 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 Manual.

(d) All outpatient BH services must be provided following established medical necessity criteria. 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

Emergency Adoptions

Provider 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.

(e) Services to nursing facility residents. Reimbursement is not allowed for outpatient behavioral health services provided to members residing in a nursing facility. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the rate paid to the nursing facility for the member's care.

(f) In addition to individual service limitations, reimbursement for outpatient behavioral health services is limited to 35 hours per rendering provider per week. Service hours will be calculated using a rolling four week average. Services not included in this limitation are:

- (1) Assessments;
- (2) Testing;
- (3) Service plan development; and
- (4) Crisis intervention services.

PART 25. PSYCHOLOGISTS

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(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 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 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.** Coverage for adults by a psychologist is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) 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. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: Depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(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) 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. 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 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 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. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four week average. 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.
- (f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

- (a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed

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to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

- (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 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 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.** Coverage for adults by a LBHP is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

- (1) 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. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.
 - (2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.
- (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) 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 a psychologist, 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 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 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. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four week average. 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.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

[OAR Docket #14-958; filed 11-13-14]

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

[OAR Docket #14-959]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 22. Health Homes [NEW]

317:30-5-250. [NEW]

317:30-5-251. [NEW]

317:30-5-252. [NEW]

317:30-5-253. [NEW]

317:30-5-254. [NEW]

(Reference APA WF # 14-16)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 2703 of the Affordable Care Act (Public Law 111-148); Section 1945 of Social Security Act

ADOPTION:

October 9, 2014

APPROVED BY GOVERNOR:

November 3, 2014

EFFECTIVE:

January 1, 2015

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual provider and specialties guidelines. These emergency revisions are necessary to improve the health status of SoonerCare members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) by promoting wellness and prevention and to improve access and continuity in healthcare for these members by supporting

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coordination and integration of primary care services in specialty behavioral healthcare settings.

ANALYSIS:

Rules are added to create coverage guidelines for Health Homes. Health Homes are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JANUARY 1, 2015, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 22. HEALTH HOMES

317:30-5-250. Purpose

Health Homes for Individuals with Chronic Conditions are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The purpose of the Health Home is to improve the health status of SoonerCare members with Serious Mental Illness or Serious Emotional Disturbance by promoting wellness and prevention and to improve access and continuity in health care for these members by supporting coordination and integration of primary care services in specialty behavioral health settings.

317:30-5-251. Eligible providers

(a) **Agency requirements.** Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider's specified service area. Qualifying providers must be:

(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or

(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or

(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or

(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.

(5) In addition to the accreditation/certification requirements in (1) - (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17; OAC 450:27; OAC 450:55).

(b) **Health Home team.** Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified

plan to empower persons toward self-management and coordinate the individual's varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.

(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:

(A) Project Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);

(E) Certified Behavioral Health Case Manager (CM)(OAC 450:50; 317:30-5-595);

(F) Wellness Coach/Peer Support Specialist (OAC 450:53; 317:30-5-240.3); and

(G) Administrative support.

(2) In addition to the individuals listed in (1)(A) through (G) above, teams working with adults with SMI (PACT teams only) will also have at least one of the following team members:

(A) Licensed Behavioral Health Professional (317:30-5-240.3);

(B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC)); or

(C) Employment specialist.

(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:

(A) Project Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);

(E) Family Support Provider (317:30-5-240.3);

(F) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3);

(G) Health Home specialist; and

(H) Administrative support.

317:30-5-252. Covered Services

Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. Coverage includes the following services:

(1) **Comprehensive Care Management.**

(A) **Definition.** Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involves the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.

(B) **Service requirements.** Comprehensive care management services include the following, but are not limited to:

- (i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;
 - (ii) Assessing preliminary service needs; participating in comprehensive person-centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;
 - (iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
 - (iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines;
and
 - (v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.
- (C) **Qualified professionals.** Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers, consisting of the following required professionals and paraprofessionals:
- (i) Nurse Care Manager (RN or LPN);
 - (ii) Certified Behavioral Health Case Manager; and
 - (iii) Primary Care Practitioner.
- (2) **Care coordination.**
- (A) **Definition.** Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.
- (B) **Service requirements.** Care coordination services include the following, but are not limited to:
- (i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);
 - (ii) Ensuring integration and compatibility of mental health and physical health activities;
 - (iii) Providing on-going service coordination and link members to resources;
 - (iv) Tracking completion of mental and physical health goals in member's Comprehensive Care Plan;
 - (v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;
 - (vi) Appointment scheduling;
 - (vii) Conducting referrals and follow-up monitoring;
 - (viii) Participating in hospital discharge processes; and
 - (ix) Communicating with other providers and members/family.
- (C) **Qualified professionals.** Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes. Care coordination services are provided by a primary care practitioner-led team which includes the following professionals:
- (i) Nurse Care Manager (RN or LPN);
 - (ii) Licensed Practical Nurse (LPN); and
 - (iii) Certified Behavioral Health Case Managers.
- (3) **Health promotion.**
- (A) **Definition.** Health promotion consists of providing health education specific to the member's chronic condition.
- (B) **Service requirements.** Health promotion will minimally consist of the following, but is not limited to:
- (i) Providing health education specific to member's condition;
 - (ii) Developing self-management plans with the member;
 - (iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:
 - (I) Substance use prevention;
 - (II) Smoking prevention and cessation;
 - (III) Obesity reduction and prevention;
 - (IV) Nutritional counseling; and
 - (V) Increasing physical activity.
- (C) **Qualified professionals.** Health promotion services must be provided by the Primary Care Practitioner, Registered Nurse Care Manager (or LPN within full scope of practice) and the Wellness Coach/Health Home specialist at the direction of the Project Director.
- (4) **Comprehensive transitional care.**
- (A) **Definition.** Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.
- (B) **Service requirements.** In conducting comprehensive transitional care, the Nurse Care Manager and the case manager will work as co-leads. The duties of the Nurse Care Manager or the case manager include, but are not limited to the following:
- (i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;
 - (ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and

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- (iii) Motivate hospital staff to notify the Health Home staff of such opportunities.
- (5) **Individual and family support services**
- (A) **Definition.** Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self-manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.
- (B) **Service requirements.** Individual and family support services include, but are not limited to:
- (i) Teaching individuals and families self-advocacy skills;
- (ii) Providing peer support groups;
- (iii) Modeling and teaching how to access community resources;
- (iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and
- (v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.
- (C) **Qualified individuals.** Individual and family support service activities must be provided by one of the following:
- (i) Wellness Coaches/Recovery support specialist/Health Home specialist; or
- (ii) Care coordinators; or
- (iii) Family Support Providers.
- (6) **Referral to community and social support services**
- (A) **Definition.** Provide members with referrals to community and social support services in the community.
- (B) **Service requirements.** Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:
- (i) Healthcare;
- (ii) Disability benefits;
- (iii) Housing;
- (iv) Transportation;
- (v) Personal needs; and
- (vi) Legal services.
- (C) **Limitations.** For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

317:30-5-253. Reimbursement

- (a) In order to be eligible for payment, HHs must have an approved Provider Agreement on file with OHCA. Through this agreement, the HH assures that OHCA's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed annually with each provider.

- (b) A Health Home may bill up to three months for outreach and engagement to a member attributed to but not yet enrolled in a Health Home. The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the HH receives reimbursement for qualified HH services.
- (c) The HH will be reimbursed a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in 317:30-5-251.

317:30-5-254. Limitations

- (a) Children/families for whom case management services are available through OKDHS/OJA staff are not eligible for concurrent Health Home services.
- (b) The following services will not be reimbursed separately for individuals enrolled in a Health Home:
- (1) Targeted case management;
- (2) Service Plan Development, moderate and low complexity;
- (3) Medication training and support;
- (4) Peer recovery support;
- (5) Peer to Peer support (family support);
- (6) Medication management and support and coordination linkage when provided within a Program of Assertive Community Treatment (PACT);
- (7) Medication reminder;
- (8) Medication administration;
- (9) Outreach and engagement.

[OAR Docket #14-959; filed 11-13-14]

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

[OAR Docket #14-960]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41.2. [AMENDED]
317:35-5-41.3. [AMENDED]
317:35-5-42. [AMENDED]
(Reference APA WF #14-17)

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(f) of the Social Security Act; 42 CFR §435.120; 1915(c) Home and Community Based Services Waiver

ADOPTION:

November 13, 2014

APPROVED BY GOVERNOR:

November 3, 2014

EFFECTIVE:

Immediately upon governor's approval or January 1, 2015, whichever is later

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the eligibility guidelines for determining financial eligibility for Aged, Blind, and Disabled individuals applying for Medicaid Services. These emergency revisions are necessary to come into compliance with federal regulations for OHCA to transition to the Supplemental Security Income (SSI) criteria administrative option. Without the recommended revisions, the Agency is at risk of losing its Federal Financial Participation to maintain the State's Medicaid Program. Revisions are aligned with Special Terms and Conditions of the 1915(c) Home and Community Based Services Waiver.

ANALYSIS:

SoonerCare rules regarding enrollment eligibility for individuals categorically related to the Aged, Blind, and Disabled population are aligned to match that of the Social Security Administration's rules for determining SSI eligibility. Policy changes include adding new language regarding the Asset Verification System to check the income or resources of ABD applicants held at fiscal institutions, updating how resources are counted towards the maximum resource limit, exempting the value of one automobile regardless of its value from the maximum resource limit, expanding the income disregards list, and disregarding \$20 unearned of income. State Plan changes include removing references of eligibility criteria that is more restrictive than SSI.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR JANUARY 1, 2015, WHICHEVER IS LATER AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.2. Miscellaneous Personal property

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

(b) **Cash savings and bank accounts.** Money on hand or in a savings account is considered as a countable resource. ~~The member's statement that he/she does not have any money on hand or on deposit is sufficient unless there are indications to the contrary. When there is information to the contrary or when the member does not have records to verify the amount~~

~~on deposit, verification is obtained from bank records. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an Asset Verification System (AVS).~~ Title 56, O.S., Section 1671 provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the member or the Agency.

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

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

(c) **Life insurance policies.** If the total face value of all life insurance policies owned by an individual is \$1500 or less, the policies (both face value and cash surrender value) are excluded as resources. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

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

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

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

(4) Dividends which accrue and which remain with the insurance company increase the amount of resource. Dividends which are paid to the member are considered as income if the life insurance policy is not an excluded resource.

(5) If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable

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

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

(e) **Burial funds.** Revocable burial funds not in excess of \$1500 are excluded as a resource if the funds are specifically set aside for the burial arrangements of the individual or the individual's spouse. Any amount in excess of \$1500 is considered as a resource. Burial policies which require premium payments and do not accumulate cash value are not considered to be prepaid burial policies. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through the AVS.

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

(2) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (1) of this subsection. The \$1500 burial fund exclusion must also be reduced by the face value of a life insurance policy for which a funeral provider has been made the irrevocable beneficiary, if the life insurance policy owner has irrevocably waived his or her right to, and cannot obtain, any cash surrender value the life insurance policy may generate.

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

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

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

(f) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. The irrevocability cannot become effective until 30 days after purchase. For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner). In instances where the OKDHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) If the irrevocable election was made prior to July 1, 1986, and the member received assistance on July 1, 1986, the full amount of the irrevocable contract is not considered a countable resource. This exclusion applies only if the member does not add to the amount of the contract. Interest accrued on the contract is not considered as added by the member. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (2) of this subsection.

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

(A) the face value amount of an irrevocable burial contract cannot exceed \$6,000 plus accrued interest through August 4, 1998;

(B) the face value amount of an irrevocable burial contract cannot exceed \$7,500 plus accrued interest for the period August 5, 1998, through October 31, 2009;

(C) after November 1, 2009, state statute excludes the face value of an irrevocable burial contract, up to \$10,000. This exclusion includes any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed \$1500. ~~When the amount exceeds \$10,000, the member is ineligible for assistance.~~ After \$10,000 is excluded, any remaining value of the irrevocable burial contract is counted against the resource limit. Accrued interest is not counted as a part of the \$10,000 limit regardless of when it is accrued; and

(D) the face value of life insurance policies used to fund burial contracts is counted towards the \$10,000 limit.

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

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

Automobiles, pickups, and trucks are considered in the eligibility determination for SoonerCare benefits. Verification of the member's countable resources held in bank accounts or at other financial institutions can be established through an AVS.

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

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

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

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

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

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

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

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. 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. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together are considered.

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of \$99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 \times 4.3 = \$429.57$ rounds to \$430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) **Income disregards.** In determining need, the following are not considered as income:

(1) ~~The coupon allotment under the Food Stamp Act of 1977~~ The value of Supplemental Nutrition Assistance Program (food stamps) received;

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

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

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

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

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- (B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.
- (C) Proceeds of a loan secured by an exempt asset are not an asset;
- (5) One-third of child support payments received on behalf of the disabled minor child;
- (6) Indian payments (including judgment funds or funds held in trust) 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 funds after distribution is considered as any other income;
- (7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;
- (8) Title III benefits from State and Community Programs on Aging;
- (9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
- (10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
- (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) 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 allowance if the uniform is uniquely identified with company names or logo;
- (14) Assistance or services 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 complementary payments;
- (15) 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;
- (16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
- (17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments, or utilities;
- (18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;
- (19) 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.);
- (20) 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;
- (21) 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;
- (22) Income of a sponsor to the sponsored eligible alien;
- (23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;
- (24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
- (25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;
- (26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;
- (27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);
- (28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
- (29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
- (30) 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~~

(31) Wages paid by the Census Bureau for temporary employment related to Census activities;

(32) Income tax refunds;

(33) Home energy assistance;

(34) Food or shelter based on need provided by non-profit agencies;

(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);

(36) Earnings up to \$1,750 per month to a maximum of \$7,060 per year (effective January 2014) for a student under age 22;

(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and

(38) The first \$2,000 of compensation received per calendar year for participating in certain clinical trials.

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to \$90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to \$90 per month. None of the \$90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the \$90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits,

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the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) Lump sum payments.

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) 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. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) Income from capital resources and rental property. Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights, or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two

~~month's~~months' royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from ~~rent~~rental property is treated as unearned income.

(iii) When ~~property~~rental ~~rental~~ property is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) Earned income/self-employment. The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission, or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. 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 his/her business enterprise. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business ~~expense~~expenses and appropriate earned income disregards.

(iii) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount, as well as the allowable deductions, are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's 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.

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and 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 given in OAC 340:10-3-33(1)).

(iv) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of \$10 or less per month or \$30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two ~~month's~~ months' income, if possible, to determine income eligibility. Less than two ~~month's~~ months' 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:

(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(ii) **Weekly.** Income received weekly is multiplied by 4.3.

(iii) **Twice a month.** Income received twice a month is multiplied by 2.

(iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

(1) **Earned income or unearned income.** The general income exclusion of \$20 per month is allowed for earned or unearned income, unless the unearned income is SSP, on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the \$20 exclusion, deduct \$65 and one-half of the remaining combined earned income. The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered.

~~(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.~~

(32) **Countable income.** The countable income is the sum of the earned income ~~after exclusions~~ and the total gross unearned income after exclusions.

(43) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) ~~An~~ intellectually disabled child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9- 5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(54) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered

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disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(65) Procedures for deducting ineligible minor child allocation. When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(76) Special exclusions for blind individuals. Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

- (A) transportation to and from work;
- (B) job performance; and
- (C) job improvement.

[OAR Docket #14-960; filed 11-13-14]

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

[OAR Docket #14-957]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:

- Subchapter 1. Medically Fragile Waiver Services
317:50-1-14. [AMENDED]
- Subchapter 3. My Life, My Choice
317:50-3-14. [AMENDED]
- Subchapter 5. Sooner Seniors

317:50-5-14. [AMENDED]
(Reference APA WF # 14-14)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, 42 CFR 441.301

ADOPTION:

September 11, 2014

APPROVED BY GOVERNOR:

November 3, 2014

EFFECTIVE:

Immediately upon governor's approval

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds substantial evidence that this rule is necessary as an emergency measure to avoid violation of federal regulation. This necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's general scope and administration guidelines. These emergency revisions are necessary to comply with the federal guidelines regarding conflict of interest provisions for case management services. The regulation states providers of Home and Community Based Services (HCBS) for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person centered service plan. Without the recommended changes, the State is out of compliance with CMS and may be in risk of losing federal funding.

ANALYSIS:

Policy is revised to include all 1915(c) waiver programs to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. The regulation states providers of Home and Community Based Services (HCBS) for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person centered service plan.

CONTACT PERSON:

Tywanda Cox at (405)522-7153

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

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

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.

(D) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(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.

(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.

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(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.

(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, or actual acquisition cost plus 30 percent.

(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. 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.

(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.

(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.

(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

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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) **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) **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.

(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.

(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.

(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.

(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.

(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

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- (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.

SUBCHAPTER 3. MY LIFE, MY CHOICE

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

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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.

(D) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(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.

(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.

(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 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.

(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 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

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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) **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) **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) **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) **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) **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.

(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.

(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,

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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.

(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.

(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.

(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.

(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;

(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.

(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.

(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 identify other alternatives to meet identified needs above the limit.

(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.

(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.

(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.

(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.

(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.

(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.

(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.

(30) **Pharmacological Therapy Management.** Pharmacological Therapy Management will utilize individual case management techniques for qualifying waiver members. Medication profiles will be reviewed for therapeutic duplication, drug-drug interactions, drug-disease interactions, contraindications, appropriate dosing and other measures of therapeutic appropriateness using principles of evidence-based medicine from peer-reviewed literature. Members are selected for therapy management based on medication utilization, or if they are referred to the program by a care manager.

(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,

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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.

(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 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).**

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(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.

SUBCHAPTER 5. SOONER SENIORS

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.

(D) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(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.

(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.

(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 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.

(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 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

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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.

(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.

(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.

(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.

(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.

(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.

(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

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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.

(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.

(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.

(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;

(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.

(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.

(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.

(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.

(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.

(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.

(24) **Pharmacological Therapy Management.** Pharmacological Therapy Management will utilize individual case management techniques for qualifying waiver members. Medication profiles will be reviewed for therapeutic duplication, drug-drug interactions, drug-disease interactions, contraindications, appropriate dosing and other measures of therapeutic appropriateness using principles of evidence-based medicine from peer-reviewed literature. Members are selected for therapy management based on medication utilization, or if they are referred to the program by a care manager.

(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.

(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 area;
- (ii) member's health and safety with Self-Directed services can reasonably be assured based

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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 #14-957; filed 11-13-14]

**TITLE 800. DEPARTMENT OF WILDLIFE
CONSERVATION
CHAPTER 10. SPORT FISHING RULES**

[OAR Docket #14-961]

**RULEMAKING ACTION:
EMERGENCY adoption**

Emergency Adoptions

RULES:

- Subchapter 1. Harvest and Possession Limits
- 800:10-1-3. Additional definitions [AMENDED]
- 800:10-1-4. Size limits on fish [AMENDED]
- 800:10-1-5. Bag limits on fish [AMENDED]
- Subchapter 3. Methods of Taking
- 800:10-3-5. Use of bow and arrow, grabhooks, gigs, spears, and spearguns, snagging, noodling and netting
- Subchapter 5. Area Restrictions and Special Fees
- 800:10-5-2. Department fishing areas [AMENDED]

AUTHORITY:

Title 29 O.S., Sections 3-103, 5-401, Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

ADOPTION:

October 6, 2014

APPROVED BY GOVERNOR:

November 3, 2014

EFFECTIVE:

Immediately upon Governor's approval.

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the legislature.

SUPERSEDED EMERGENCY ACTION:

n/a

INCORPORATED BY REFERENCE:

n/a

FINDING OF EMERGENCY:

American Horse Lake

American Horse Lake in Blaine County was drained to complete repairs to the dam. The lake was closed to public access during the construction phase for safety reasons. The lake will be re-opened this fall and emergency rules are needed to protect the bass population from overharvest. Boat ramps are not usable, so an emergency rule to restrict boats is also required.

Doc Hollis Lake in Greer County was recently purchased by ODWC. Emergency rules are needed to set hunting and fishing regulations, protect the bass fishery from overharvest and prevent the spread of golden alga from other lakes in southwest Oklahoma.

Carl Etling Lake

Carl Etling Lake in Cimarron County will be stocked with tiger muskie in October 2014. ODWC hopes to develop a trophy tiger muskie fishery and emergency rules are needed to protect the fish from harvest.

ANALYSIS:

These emergency rules will add Doc Hollis Lake to "Department Fishing Areas", remove the 14 inch length limit on bass at American Horse Lake, set catch and release only bag limits for bass at Doc Hollis and American Horse Lakes, set catch and release only bag limits for tiger muskie statewide, prohibit bowfishing for tiger muskie statewide, prohibit boats and motors at Doc Hollis and American Horse Lakes, and set hunting regulations at Doc Hollis Lake.

CONTACT PERSON:

Barry Bolton, Chief of Fisheries Division, Oklahoma Department of Wildlife Conservation, 1801 N. Lincoln Blvd., Oklahoma City, Ok 73105. Phone: 405/521-3721 or Rhonda Hurst, APA Liaison, phone: 405/522-6279.

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

SUBCHAPTER 1. HARVEST AND POSSESSION LIMITS

800:10-1-3. Additional definitions

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

"**Department fishing areas**" means lakes American Horse, Burtschi, Chambers, Dahlgren, Doc Hollis, Elmer, Etling, Fugate, Hall, Jap Beaver, Nanih Waiya, Ozzie Cobb, Raymond Gary, Schooler, Vanderwork, Vincent, Watonga, the Blue River Public Fishing and Hunting Area and the Lower Illinois River Public Fishing and Hunting Area - Simp and Helen Watts Management Unit.

"**No culling**" means fish caught and placed on a stringer or otherwise held in possession (live well, basket, ice chest, etc.) cannot be released.

"**Total length**" means measured from the tip of the snout to the end of the tail, with the fish laid flat on the rule with mouth closed and tail lobes pressed together.

"**Close To Home**" fishing waters means bodies of water designated as such under a cooperative fisheries management agreement between ODWC and participating cities and/or municipalities. "Close to Home" fishing waters shall be designated in the Oklahoma Department of Wildlife Conservation Oklahoma Fishing Guide which is published annually.

800:10-1-4. Size limits on fish

There are no length and/or size limit restrictions on any game or nongame fish, except as follows:

- (1) All largemouth and smallmouth bass less than fourteen (14) inches in total length must be returned to the water unharmed immediately after being taken from public waters unless regulated by specific municipal ordinance or specified in regulations listed below: Lakes and Reservoirs with no length limit on largemouth and smallmouth bass - Lake Murray, all waters in the Wichita National Wildlife Refuge, ~~and American Horse Lake.~~
- (2) All largemouth and smallmouth bass between thirteen (13) and sixteen (16) inches in total length must be returned unharmed immediately after being taken from lakes Chimney Rock (W.R. Holway), Arbuckle, Okmulgee and Tenkiller Lake (downstream from Horseshoe Bend boat ramp).
- (3) All crappie (*Pomoxis* sp.) less than 10 inches in total length must be returned to the water unharmed immediately after being taken from Lakes Arbuckle, Tenkiller, Hudson, Texoma, Ft. Gibson, including all tributaries and upstream to Markham Ferry Dam and Grand Lake, including all tributaries to state line.
- (4) All walleye, sauger, and saugeye (sauger x walleye hybrid) less than 18 inches in total length must be returned to the water unharmed immediately after being taken statewide, except at Altus-Lugert, Ellsworth, Foss, Fort Cobb, Lawtonka, Tom Steed, Waurika and Murray lakes and the respective tailwaters, where walleye, sauger and saugeye less than 14 inches in total length must be returned to the water unharmed immediately and at Great Salt Plains Reservoir and tailwater where the size limit does not apply and in the Illinois River below Tenkiller Dam and the Arkansas River from Keystone Dam downstream to the Oklahoma state line where all sauger less than 16 inches must be returned to the water unharmed immediately.

(5) All largemouth and smallmouth bass between sixteen (16) and twenty-two (22) inches in total length must be returned to the water immediately after being taken from McGee Creek Lake, Dripping Springs Lake and Crowder Lake (Washita County).

(6) All rainbow trout less than twenty (20) inches in total length must be returned to the water immediately after being taken from the lower Mountain Fork River trout stream from the Lost Creek water control structure downstream to the first Highway 259 Scenic bridge, including Evening Hole and the Lost Creek stream channel, and from the State Park Dam downstream to the mouth of Rough Branch Creek and in the lower Illinois River trout stream from the USGS stream gauge downstream to the gravel pit county road. All brown trout less than twenty (20) inches in total length must be returned to the water immediately after being taken from the lower Mountain Fork River from Broken Bow Dam downstream to the U. S. Highway 70 bridge, and from the lower Illinois River trout stream from Tenkiller Dam downstream to the U. S. Highway 64 bridge.

(7) All blue catfish and channel catfish less than twelve (12) inches in total length must be returned to the water unharmed immediately after being taken from Texoma Lake.

(8) All smallmouth bass less than fourteen (14) inches in total length must be returned to the water unharmed immediately after being taken from all rivers and streams including the Illinois River upstream from the Horseshoe Bend boat ramp, and from the Glover River from the confluence with the Little River upstream to the 'Forks of the Glover River'. Possession of smallmouth bass less than fourteen (14) inches in total length on all streams and rivers is prohibited.

(9) All black bass (largemouth, spotted and smallmouth) less than fourteen (14) inches in total length must be returned unharmed immediately after being taken from the Blue River Public Fishing Area.

(10) All striped bass less than twenty (20) inches must be returned unharmed immediately after being taken from Sooner Reservoir.

800:10-1-5. Bag limits on fish

No person shall, during any one day, take, attempt to take, kill, or harvest more than:

(1) Six (6) largemouth or smallmouth bass or six in aggregate, except in "Close To Home" fishing water, Doc Hollis Lake and at American Horse Lake where all largemouth bass caught must be returned to the water unharmed immediately after being taken (no harvest allowed), at Texoma Reservoir where the limit is five (5), largemouth, smallmouth or spotted bass or five in aggregate, at Lake Konawa, McGee Creek Lake, Dripping Springs Lake and Crowder Lake (Washita County) where the limit is six (6) of which only one (1) may be twenty-two (22) inches or longer and rivers and streams including the Illinois River upstream from the Horseshoe Bend boat ramp, and from Glover River from the confluence with the Little River upstream to the "Forks of the Glover River" where the

limit is six (6) black bass aggregate of which only one may be a smallmouth bass, which must be fourteen (14) inches or longer.

(2) Fifteen (15) channel and/or blue catfish, or fifteen (15) in aggregate, of which only one (1) blue catfish may be 30 inches in length or larger; except at all U.S. Forest Service and State Park lakes (not including Lake Murray) and Department of Wildlife Management Area ponds and all Department of Wildlife Conservation fishing areas, in "Close To Home" fishing waters and all waters within the Wichita Mountains National Wildlife Refuge, where the limit is six (6). Ten (10) flathead catfish, except in Lake Texoma where the daily limit is five (5). For noodlers and scuba divers the daily limit is three (3) blue, channel, or flathead catfish or three in aggregate of which only one can be 30 inches or longer from May 1 through August 31, annually.

(3) Thirty-seven (37) crappie (*Pomoxis* sp.) except at Blue River Public Fishing and Hunting Area where the limit is six (6) and at lakes Arbuckle, Tenkiller, Hudson, Ft. Gibson including all tributaries and upstream to Markham Ferry Dam and Grand Lake including all tributaries to state line where the limit is fifteen (15).

(4) Six (6) rainbow trout - possession limit of twelve (12) after first day, except in the lower Mountain Fork River trout stream from the Lost Creek water control structure downstream to the first Highway 259 Scenic bridge, including Evening Hole and the Lost Creek stream channel, and from the State Park Dam downstream to the mouth of Rough Branch Creek, and in the lower Illinois River trout stream from the USGS stream gauge downstream to the gravel pit county road where the limit is one (1) rainbow trout per day twenty (20) inches or longer in total length (no culling); and in the Blue River from its entry onto the Plaster Wildlife Management Unit/Landrum Wilderness downstream approximately ½ mile to a marker cable where all trout caught must be released immediately from November 1 to March 1 (thereafter, statewide trout bag limit applies).

(5) Six (6) brown trout, except in the lower Mountain Fork River trout stream below Broken Bow dam downstream to the U. S. Highway 70 bridge, and in the lower Illinois River trout stream from Tenkiller Dam downstream to US Highway 64 bridge where the limit is one (1) fish per day twenty (20) inches or longer in total length.

(6) Six (6) walleye, sauger and/or saugeye, or six (6) in aggregate.

(7) Five (5) striped bass except as designated in 800:10-1-5(8).

(8) Ten (10) striped bass and/or striped bass hybrids or ten (10) in aggregate of which only two (2) may be twenty (20) inches or longer in Texoma Reservoir.

(9) Twenty (20) striped bass of which only five (5) may be twenty (20) inches or longer, except as designated in 800:10-1-5(8) and (10).

(10) Five (5) striped bass and/or striped bass hybrids, in aggregate, of which only two (2) may be 20 inches or longer in Arcadia Lake and Skiatook Lake.

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(11) Twenty-five (25) white bass in Lake Texoma.

(12) One (1) paddlefish (*Polyodon spathula*) per day on Sunday, Tuesday, Wednesday, Thursday, and Saturday, statewide. Catch and release of paddlefish only (no harvest) is permitted on Monday and Friday, statewide. Possession of paddlefish in the field is prohibited on Monday and Friday, statewide. The catch and release of paddlefish is permitted by use of rod and reel, trotline and throwlines. Paddlefish must be released immediately unless kept for the daily limit. Paddlefish taken by bow and arrow, gigs, spears or spearguns shall not be released.

(A) Individual annual harvest limit- An individual harvest limit for paddlefish may be set or amended annually by the Wildlife Conservation Commission and will be listed in the Oklahoma Department of Wildlife Conservation Fishing Guide. Special area (or management unit) paddlefish harvest caps, a general statewide paddlefish harvest cap, and the total number of paddlefish permits issued may be set or amended annually by the Wildlife Conservation Commission for use in determining the individual annual harvest limit. Once an individual angler has reached their annual harvest limit, continued catch and release is permitted.

(B) Paddlefish permit- It shall be unlawful for any person, regardless of residency, age or disability, to fish for paddlefish or be in possession of paddlefish parts without having first secured from the Department of Wildlife Conservation, an annual paddlefish permit. Immediately upon taking possession of a paddlefish with the intent of harvesting said fish, the angler must record the date and time of harvest on the paddlefish permit in the harvest record area provided. This permit must be carried on their person while fishing and/or in possession of paddlefish or parts and be produced for inspection upon the demand of any Oklahoma citizen or game warden. This permit shall be valid for paddlefish catch and release fishing in all waters of the state and at any time unless otherwise prohibited.

(C) Harvest Tagging- Paddlefish caught and placed on a stringer or otherwise held in possession must be plainly labeled (tagged) immediately with the angler's paddlefish permit number. Paddlefish taken into possession cannot be released (no culling). Each person must keep their own paddlefish distinctly separate from paddlefish taken by other anglers. Each cleaned paddlefish, or its meat, eggs, or carcass, must be kept separate from all other cleaned paddlefish or its parts. Paddlefish or their parts must remain tagged until the person in possession of the paddlefish or paddlefish parts has reached their residence. All paddlefish must have all viscera (internal organs) removed from the paddlefish before leaving the state. Persons fishing trotlines or throwlines must release all paddlefish on their lines, except the one (1) paddlefish held in possession for their daily limit, before leaving the trotline or throwline. Anglers must cease snagging

for the day when they have taken their daily limit of paddlefish into possession.

(D) Reporting- Harvest of paddlefish must be reported by the harvesting angler to Oklahoma Department of Wildlife within 24 hours of harvest. Instructions for reporting harvest will be provided in the Oklahoma Department of Wildlife Fishing Guide and on the Oklahoma Department of Wildlife website.

(13) Release of striped bass and/or striped bass hybrids caught and placed on a stringer, in a live well or otherwise held in possession is prohibited statewide (no culling).

(14) One (1) alligator gar (*Atractosteus spatula*) per day, statewide, except during the period of May 1 through May 31 when angling for alligator gar by all angling methods is prohibited on Lake Texoma between the Highway 99 bridge upstream to the I-35 bridge. The catch and release of alligator gar is permitted year round, except during the closure referenced above, by use of rod and reel, trotline and throwlines. Alligator gar must be released immediately unless kept for the daily limit. Persons fishing trotlines or throwlines must release all alligator gar on their lines except the one alligator gar held in possession for their daily limit, before leaving the trotline or throwline. Alligator gar taken by bow and arrow, gigs, spears or spearguns shall not be released. Alligator gar caught and placed on a stringer or otherwise held in possession cannot be released (no culling). Anglers must cease snagging when they have taken their daily limit of alligator gar into possession.

(15) One (1) of any fish species classified as those of Special Concern Category I or Category II (as identified in 800:25-19-6). Such harvest must be reported to ODWC.

(16) All tiger muskie (*Esox masquinongy* x *Esox lucius*) caught must be returned to the water unharmed immediately after being taken (no harvest allowed).

~~(17)~~ Other fish do not have bag or possession limits. Notwithstanding the foregoing fish bag limits, any bag limits for fish can be superseded and set by Commission resolution as authorized by Section 6-302(B) of Title 29 of the Oklahoma Statutes.

SUBCHAPTER 3. METHODS OF TAKING

800:10-3-5. Use of bow and arrow, grabhooks, gigs, spears, and spearguns, snagging, noodling and netting

(a) **Bow and arrow.** The use of bow and arrows in bowfishing shall be lawful for taking nongame fish only in all waters of the state throughout the year, except:

(1) Illinois River and its tributaries shall be closed at all times to such fishing except, those portions above the Horseshoe Bend boat ramp on Tenkiller Reservoir which is open from December 1 through March 31 annually. Tenkiller Reservoir below Horseshoe Bend boat ramp is open to bowfishing.

- (2) Reservoir tailwaters, other than Eufaula, Keystone, Wister, Fort Gibson, Thunderbird and Hudson (Markham Ferry) shall be closed to fishing with bow and arrows throughout the year. This does not alter provisions of 29 O.S., Section 7-101, which designates a safety zone of the first 150 feet immediately below the dam on all reservoirs except Tenkiller, Canton, Salt Plains, and Fort Supply.
 - (3) All waters defined as "Designated Trout Areas" during open season for taking trout are closed.
 - (4) All waters within the boundaries of the Wichita Mountains Wildlife Refuge are closed.
 - (5) Only that section of the Caney River from Hulah Dam downstream approximately 1,200 feet to the re-regulation dam is closed. Fishing with a bow and arrow is lawful in the Caney River below the re-regulation dam.
 - (6) The following portions of Grand River:
 - (A) The main river channel of Grand River below the turbine outlets of Grand River Dam downstream to the State Park Bridge is closed throughout the year.
 - (B) The Grand River occurring below the spillway outlets of Grand River Dam downstream to the highline crossing (approximately $\frac{1}{2}$ mile) is closed throughout the year with the next $\frac{1}{2}$ mile downstream from the highline crossing closed during periods when the spillway gates are open and discharging water and for seven (7) days following closure of the spillway gates.
 - (7) The Little River tributary of Thunderbird Reservoir above Franklin Road in Cleveland County is closed.
 - (8) "Close To Home" fishing waters and Lakes Pickens, Carl Albert and Taft and all ponds and lakes in the Ouachita National Forest are closed.
 - (9) The taking of paddlefish by bow and arrow is prohibited on the Red River from Denison Dam downstream to the stateline year round.
 - (10) Bowfishing may be used at Lakes Hefner, Overholser (including tailwaters and downstream to NW 10th St. bridge) and Draper throughout the year during daylight hours only.
 - (11) The Salt Fork of the Arkansas River from the spillway of Great Salt Plains Reservoir downstream to the State Highway 38 Bridge is closed.
 - (12) Bowfishing for tiger muskie at Lake Carl Etling is prohibited.
- (b) **Grabhooks.** Taking fish by use of a grabhook is prohibited in all state waters.
- (c) **Gigs, spears and spearguns.** The use of gigs, spears and spearguns containing not more than three (3) points with no more than two (2) barbs on each point shall be lawful for taking nongame fish only, except white bass may be taken by use of a gig. These methods are lawful in all:
- (1) Rivers and streams from December 1 through March 31, except:
 - (A) The taking of paddlefish by use of gig, spear or speargun is prohibited from May 16 through March 14 of the following year, statewide.
- (B) The Poteau and Fourche Maline Rivers and all their tributaries within LeFlore County are closed throughout the year.
- (C) All waters designated as "Designated Trout Areas" during the open season for taking trout are closed.
- (D) The Canadian River from Eufaula Dam downstream for a distance of one (1) mile to be so designated by buoy or other appropriate marker is closed throughout the year.
- (E) The Caney River from Hulah Dam downstream to the confluence of the old and new river channels is closed.
- (F) The following portions of Grand River:
 - (i) The main river channel of the Grand River below the turbine outlets of Grand River Dam downstream to State Park Bridge is closed throughout the year.
 - (ii) The Grand River occurring below the spillway outlets of Grand River Dam downstream for a distance of one (1) mile is closed throughout the year.
- (G) Rivers and streams in Delaware and Mayes counties are open to the use of gigs throughout the year, unless specifically closed in other sections of this chapter.
- (H) The Little River tributary of Thunderbird Reservoir above Franklin Road in Cleveland County is closed.
- (2) Lakes and reservoirs throughout the year, except:
 - (A) Waters within the boundaries of the Wichita Mountains Wildlife Refuge other than that portion of Lake Elmer Thomas are closed.
 - (B) Tenkiller Reservoir, below the Horseshoe Bend boat ramp, is closed throughout the year except by speargunning when used with a self-contained underwater breathing apparatus which is closed from June 15 through July 15 annually to the taking of flathead catfish only.
 - (C) All Department Fishing Areas, all "Close To Home" fishing waters and Lakes Carl Albert, Sooner, Lone Chimney and Taft and all ponds and lakes in the Ouachita National Forest are closed. Konawa is closed to gigging.
 - (D) Lakes Hefner, Overholser (including tailwaters and downstream to NW 10th St. bridge) and Draper are closed.
- (3) Reservoir tailwaters other than Hudson (Markham Ferry) shall be closed to fishing with gigs, spears and spearguns throughout the year. This does not alter provisions of 29 O.S., Section 7-101, which designates a safety zone of the first 150 feet immediately below the dam on all reservoirs except Tenkiller, Canton, Salt Plains, and Fort Supply.
- (d) **Snagging.** Snagging for nongame fish only shall be lawful in all waters of the State throughout the year, except:
 - (1) Reservoir tailwaters other than Fort Gibson which is open 24 hours a day, and Wister which is open from 10 p.m. to 6 a.m.; shall be closed to fishing by snagging

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throughout the year. This does not alter provisions of 29 O.S., Section 7-101, which designates a safety zone of the first 150 feet immediately below the dam on all reservoirs except Tenkiller, Canton, Salt Plains, and Fort Supply.

(2) The following rivers, lakes, and streams:

(A) The Illinois River and its tributaries above the Horseshoe Bend boat ramp on Tenkiller Reservoir and below the dam shall be closed at all times to such fishing.

(B) All waters designated as "Designated Trout Areas" during the open season for taking trout are closed.

(C) All waters within the boundaries of the Wichita Mountains Wildlife Refuge are closed.

(D) The Canadian River from Eufaula Dam tailwater Downstream for a distance of one (1) mile to be so designated by buoy or other appropriate marker is closed throughout the year.

(E) The Caney River from the Hulah Dam downstream to the confluence of the old and new river channels is closed.

(F) The following portions of the Grand River:

(i) The main river channel of Grand River below the turbine outlets of Grand River Dam downstream to the State Park Bridge is closed throughout the year.

(ii) That portion of the Grand River occurring below the spillway outlets of Grand River Dam downstream to the highline crossing (a distance of approximately $\frac{1}{2}$ mile) is closed throughout the year with the next $\frac{1}{2}$ mile downstream from the highline crossing closed during periods when the spillway gates are closed.

(iii) That portion of the Grand River occurring from the Markham Ferry Dam (Lake Hudson Dam) downstream to the Highway 412 bridge from 10 p.m. to 6 a.m. year-round.

(G) The Arkansas River from the tailwaters below Keystone Dam downstream to the Interstate 44 (Skelly Drive) Bridge at Tulsa shall be closed at all times to such fishing.

(H) The Little River tributary of Thunderbird Reservoir above Franklin Road in Cleveland County is closed.

(I) All Department Fishing Areas, all "Close To Home" fishing waters and Lakes Pickens, Carl Albert, Sooner and Konawa and all ponds and lakes in the Ouachita National Forest are closed.

(J) Lakes Hefner, Overholser (including tailwaters and downstream to NW 10th St. bridge) and Draper are closed.

(3) When snagging for paddlefish the hook must have the barbs removed or completely closed. Only one (1) rod and reel is permitted per angler when snagging.

(e) **Noodling.** Possession of hooks, gaffs, spears, poles with hooks attached and/or ropes with hooks attached while in the act of noodling, shall be proof of violation of the "hands only" noodling law. Noodling shall be lawful for nongame fish and

blue, channel, and flathead catfish; only during daylight hours throughout the year.

(1) Rivers and streams of the state, except:

(A) The Illinois River and its tributaries above Horseshoe Bend boat ramp on Tenkiller Reservoir and below the dam shall be closed at all times to such fishing.

(B) All waters designated as "Designated Trout Areas" during the open season for taking trout are closed.

(C) Kiamichi River from Hugo Dam downstream to the first railroad bridge is closed.

(D) The following portions of the Grand River:

(i) The main river channel of Grand River below the turbine outlets of Grand River Dam downstream to the State Park Bridge is closed throughout the year.

(ii) The Grand River occurring below the spillway outlets of Grand River Dam downstream to the highline crossing is closed throughout the year except the day of and two (2) days following closure of the spillway gates when noodling will be legal.

(E) The Little River tributary of Thunderbird Reservoir above Franklin Road in Cleveland County is closed.

(2) Corps of Engineers and Bureau of Reclamation Reservoirs, Grand and Hudson Lakes.

(3) All waters within the boundaries of the Wichita Mountains Wildlife Refuge are closed.

(4) All Department Fishing Areas, all "Close To Home" fishing waters (except noodling is allowed in the North Canadian River from the NW 10th St. bridge downstream to the MacArthur St. bridge in Oklahoma City) and Lakes Pickens, Carl Albert, Taft, and Lone Chimney, Ponca and Carl Blackwell and all ponds and lakes in the Ouachita National Forest are closed.

(5) Lakes Hefner, Overholser (including tailwaters and downstream to NW 10th St. bridge) and Draper are closed.

(f) **Netting (noncommercial).** Netting (noncommercial) is closed statewide.

(g) **Collecting Bait for personal use.** Cast netting, trawl netting, dip netting, minnow traps and seining non-game fish commonly used for bait for personal use is lawful in all waters of this state unless specifically closed under 800:10-5-2, 800:10-5-3 and/or 800:10-5-6. Cast nets and dip nets shall have a mesh size no greater than three-eighths ($\frac{3}{8}$) inch square mesh. Seines shall not exceed twenty (20) feet in length, and the mesh shall be no larger than one-half ($\frac{1}{2}$) inch square unless seining for minnows then the mesh shall not exceed one-fourth ($\frac{1}{4}$) inch. Minnow traps shall have a mesh size no greater than one-half ($\frac{1}{2}$) inch, shall not be longer than three (3) feet, shall not exceed eighteen (18) inches in diameter on round traps or eighteen (18) inches on a side on square or rectangular traps. The trap entrance (throat) cannot exceed two (2) inches across the opening. No person shall fish with more than 3 minnow traps. All minnow traps must have the owner's name and address attached and the traps must be attended once every 24 hours. All game fish and non-game fish not commonly used

for bait must be released immediately. Minnow traps cannot be made with glass.

SUBCHAPTER 5. AREA RESTRICTIONS AND SPECIAL FEES

800:10-5-2. Department fishing areas

The following rules and restrictions govern public use on all Department Fishing Areas, including:

- (1) **Department owned lakes and access areas.** The following rules apply:
 - (A) Camping is permitted, but limited to three (3) days duration at all areas, except at the Kiamichi River Access Area and the Lower Illinois River Public Fishing and Hunting Area - Simp and Helen Watts Management Unit where no overnight camping is permitted and at Lakes Watonga, Carl Etling and the Illinois River Access Areas where camping shall be limited to fourteen (14) consecutive days. Camping is permitted only in designated camping areas.
 - (B) Boats and motors are permitted except at Doc Hollis Lake and American Horse Lake. All boats and motors must comply with existing state boat regulations and boat operators must obey Oklahoma State Boat Laws. All boats must be operated at no-wake speed (six '6' miles per hour or less) and may not be left on the water or the areas longer than the limit on camping.
 - (C) Water skiing is prohibited.
 - (D) Disposal of trash, refuse and debris is prohibited, except in designated trash containers. This includes organic and inorganic materials.
 - (E) Glass beverage containers are prohibited at Department fishing areas except in designated camping and parking areas.
 - (F) Commercial concessions and private developments on Department property are prohibited. Soliciting, advertising or promoting any commercial or private activity is prohibited. The use of these areas for any commercial operation in any way is prohibited.
 - (G) Dogs must be kept on a leash at all times, except when used to hunt with, during legal open hunting seasons on those areas where hunting is permitted.
 - (H) Boat houses, ramps, docks and other facilities may not be constructed on Department property without specific approval of the Oklahoma Wildlife Conservation Commission.
 - (I) It shall be unlawful to drive, occupy or park any motor driven vehicle, including automobiles, trucks, mini bikes, motorcycles, etc., except on maintained roads, (unless posted as "no parking zones"), designated parking areas, and designated camping areas. It shall be unlawful to operate any vehicle in a manner to create a public nuisance or to park in a "no parking zone." Operators must be licensed drivers.

- (J) Cutting or defacing of trees and vegetation shall be prohibited. Removal of any vegetation, soil, rocks, water or minerals is prohibited except under written approval of the Department Director.
- (K) Vandalism, theft, and damage to State property is prohibited.
- (L) No person shall use threatening, abusive, or indecent language, participate in a disorder assemblage, nor publicly appear nude or intoxicated on any lands owned or managed by the Oklahoma Department of Wildlife Conservation.
- (M) After 10:00 p.m., and until 5:00 a.m., all Department fishing areas will be restricted to fishing and fishing related activities only, and hunting if permitted by Commission.
- (N) Swimming is not permitted unless a designated swimming area is established by the Wildlife Conservation Commission.
- (O) Hunting is permitted on the following lakes: Hall, Jap Beaver, Burtschi, Nanih Waiya, Ozzie Cobb, Schooler, Evans-Chambers, American Horse and Vanderwork during the period of September 1 through Spring Turkey Season, including migratory bird seasons. Hunting regulations and restrictions for lakes Dahlgren, and Doc Hollis, and Vincent are the same as those listed for Lexington WMA (Dahlgren), Sandy Sanders WMA (Doc Hollis), and Ellis County WMA (Vincent). The following lakes are closed to hunting or taking of wildlife by any means: Elmer, Etling, Raymond Gary and Watonga. Hunting is restricted to shotguns or archery only. These lakes are closed to antlerless deer harvest, except during archery season. Hunting and shooting other than that provided above is prohibited. The Director may designate "closed areas" for purposes of safety and/or security.
- (P) Fishing is permitted in accordance with provisions provided in OAC 800:10, Subchapter 1. The Director may designate "closed areas" for purposes of safety and/or security.
- (Q) No person may fish with more than two (2) poles, except during trout seasons at "Designated Trout Areas" where no person may fish with more than one (1) pole.
- (R) Trotlines, throwlines, limblines, juglines, nets, seines, yo-yo's, spearguns, and the taking of any fish by noodling and the taking of bait minnows by any method is prohibited, except cast nets may be used to take bait for personal use at Lake Carl Etling.
- (S) No person shall possess, consume or use any intoxicating beverage or low-point beer, as defined in Title 37, except in camping and parking areas on any lands or waterways subject to the control of the Oklahoma Department of Wildlife Conservation except U.S. Forest Service regulations shall apply to Black Kettle, Ouachita, Rita Blanca and Tiak Wildlife Management Areas.

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(T) No person shall possess, consume, use or manufacture any controlled or dangerous substance, as defined in Title 63 on any lands or waterways subject to the control of the Oklahoma Department of Wildlife Conservation.

(U) All impoundments are catch and release only on the following Department property unless determined otherwise as published in the Oklahoma Fishing Guide: Cimarron Bluff WMA.

(2) **Blue River Public Fishing and Hunting Area.**
The following rules apply:

(A) Hunting shall be permitted during regular hunting seasons and is restricted to shotgun and long bow and arrow only. No other use or other firearms are permitted.

(B) Blue River PFHA is closed to all except emergency traffic from 10:00 p.m. to 6:00 a.m. throughout the year.

(C) Glass beverage containers are prohibited at Blue River PFHA except in designated camping and parking areas.

(D) Fishing is permitted in accordance with provisions provided in OAC 800:10, Subchapter 1.

(E) Trotlines, throwlines, noodling, limblines, spearguns, juglines, nets, seines, and yo-yo's are prohibited throughout the year.

(F) No person may fish with more than two (2) poles, except only one (1) pole and line or rod and reel is permitted during the designated trout season.

(G) The following special rules pertain to the Carl R. and Ruth Walker Landrum Wilderness and Plaster Wildlife Management Unit:

- (i) no camping
- (ii) areas closed from 10:00 p.m. to 6:00 a.m.
- (iii) no swimming
- (iv) walk-in access only (except where wheelchair access is provided).

(H) The Blue River Campground Area is closed to swimming, effective January 1, 1990, unless suitable agreement can be reached between the Department and an acceptable second party who would be responsible for managing a designated swimming area for a three month season, annually. The Department will assume no cost or liability for development and operation of a designated swimming area.

(I) Effective July 1, 2000 the following rules apply to camping at the Blue River Campground Area:

- (i) Camping is restricted to 14 days in a 30 consecutive day period. The Area Manager may grant extensions by issuing a permit for camping beyond the 14 day limit. Such extensions shall be based upon degree of area use, anticipated weekend or holiday occupancy and recreation season. Extensions shall be requested 48 hours prior to the requested date of the extension.

- (ii) Camping is permitted only in designated camping areas.

(iii) No person shall leave a vehicle, camper, tent or any personal property unattended for more than a 48-hour period without approval of the Area Manager.

(iv) If property must be removed, it will be at owners expense and liability. The unauthorized placement of camping equipment or other items on a campsite and/or personal appearance without overnight occupancy at a campsite for the purpose of reserving a designated campsite for future occupancy is prohibited.

(3) **Arcadia Conservation Education Area**

(A) Walk-in fishing permitted on all parts of the lake shoreline. No fishing in any ponds or wetland areas unless part of an ODWC sanctioned education event.

(B) Camping prohibited except as authorized by ODWC.

[OAR Docket #14-961; filed 11-13-14]

TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION CHAPTER 25. WILDLIFE RULES

[OAR Docket #14-962]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 37. Nuisance Wildlife Control Program
Part 1. Nuisance Wildlife Control Operators Program
800:25-37-1. Purpose [AMENDED]
800:25-37-2. Permit requirements [AMENDED]
800:25-37-3. Exemptions [REVOKED]
800:25-37-4. Reporting procedures [AMENDED]
800:25-37-5. Procedures and guidelines [AMENDED]

AUTHORITY:

Title 29 O.S., Sections 3-103, 4-135.1, 5-401 and HB 2618 Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

ADOPTION:

October 6, 2014

APPROVED BY GOVERNOR:

November 3, 2014

EFFECTIVE:

Immediately upon Governor is approval.

EXPIRATION:

Effective through September 14, 2015, unless superseded by another rule or disapproved by the legislature.

SUPERSEDED EMERGENCY ACTION:

n/a

INCORPORATED BY REFERENCE:

n/a

FINDING OF EMERGENCY:

These rules changes are necessary due to the creation of a new NWCO license by HB 2618 which goes into effect November 2014.

ANALYSIS:

These changes would update the Nuisance Wildlife Control Operator (NWCO) rules regarding permitting, reporting procedures and certification. They would clarify certain language to help make the rules more understandable.

CONTACT PERSON:

Robert Fleenor, Chief of Law Enforcement Division, Oklahoma Department of Wildlife Conservation, 1801 N. Lincoln Blvd., Oklahoma

City, Ok 73105. Phone: 405/521-3719 or Rhonda Hurst, APA Liaison, phone: 405/522-6279.

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

SUBCHAPTER 37. NUISANCE WILDLIFE CONTROL PROGRAM

PART 1. NUISANCE WILDLIFE CONTROL OPERATORS PROGRAM

800:25-37-1. Purpose

- (a) The purpose of this Subchapter is to establish guidelines for the permitting and certification of Nuisance Wildlife Control Operators (NWCO), and the procedures to be used by the NWCOs in controlling nuisance wildlife.
(b) NWCO will be defined as all individuals (see exemptions section) who offer their services to control nuisance wildlife.

800:25-37-2. Permit requirements

- (a) The Nuisance Wildlife Control Operator's (NWCO) Permit will be issued to any person who has successfully completed the NWCO certification course National Wildlife Control Training Program and successfully passed the certification exam to operate as a NWCO. The NWCO permit, and a NWCO Complaint Report Form and a Professional Trapping License*(see exemptions section), must be carried at all times while conducting NWCO activities.
(b) The Nuisance Wildlife Control Operator's (NWCO) Permit authorizes an individual to capture, euthanize or relocate designated species of wildlife by safe and effective means at any time of the year and without limits which may be in force on certain species of wildlife provided the operator is acting on a documented nuisance wildlife complaint detailing the nature of the complaint, target species, method of control, effective dates of control, location, and customer information including the landowner's signature.
(c) Any person whose hunting or trapping license privileges are revoked and is not legally able to purchase a hunting or trapping license, shall not possess or operate under the authority of a NWCO permit.
(d) NWCO PermitteePermittee must renew the NWCO permit annually. The annual NWCO permit is valid from January 1 through December 31. NWCOs must submit proof of:
(1) Prior year's Year End Report Summary;
(2) Current Professional Trapping License, Hunting License, Hunting and Fishing Legacy Permit or proof of exemption.
(2) Affidavit of Lawful Presence

800:25-37-3. Exemptions [REVOKED]

- (a) Employees of the Oklahoma Department of Wildlife Conservation and the Oklahoma Cooperative Wildlife Services Program are exempt from all NWCO permit requirements while they are on duty.
(b) Employees of any city, town, or county government shall be exempt from the requirement of purchasing or possessing the Annual Professional Trapping License while they are on duty but are not exempt from the certification requirements.

800:25-37-4. Reporting procedures

- (a) Nuisance Wildlife Complaint Report Forms (available from the Department) must be kept by NWCO for a period of three (3) years. Year End Report-Summary Report forms will detail the number of each species of wildlife taken during the year:
(1) number of each species of wildlife taken during the year.
(2) application for annual renewal.
(b) Such records shall be available for inspection at all reasonable times by authorized representatives of the Department.
(c) A summary of all Nuisance Wildlife Complaint Reports are to be submitted annually for each calendar year on or before January 30 of the following year and must include NWCO name or, Company name, address, and telephone number.

800:25-37-5. Procedures and guidelines

- The following regulations for a NWCO permit shall be in effect to establish what species of wildlife may be taken under such a permit, the legal methods that may be used to control nuisance wildlife under such a permit, and the legal methods of disposal of nuisance wildlife under such permit.
(1) NWCO Permittees are only authorized to trap and relocate or euthanize the following wildlife species when such action is warranted by a valid nuisance wildlife complaint including, but not limited to: armadillo, badger, bats, beaver, bobcat, coyote, jackrabbit, cottontail rabbit, fox squirrel, gray squirrel, red fox, gray fox, porcupine, mink, mountain lion, muskrat, nutria, opossum, raccoon, river otter, snakes, striped skunk, and weasel.
(2) Problems and complaints concerning deer, elk, turkey, bear, alligator, antelope, mountain lion, big horn sheep, endangered or threatened species and game birds will only be handled when specifically authorized in writing by the Director of the ODWC.
(3) The sale, trade, barter, gifting, or retention of any wildlife, or parts thereof, except coyotes and beavers, taken under authority of a NWCO permit is prohibited, except wildlife legally taken during established trapping seasons and in accordance with all other pertinent rules and laws not associated with NWCO rules may be sold or otherwise disposed of as provided by law.
(4) The sale, trade, barter, gifting or retention of beavers, coyotes, or parts thereof, taken under authority of a NWCO permitted is allowed with the proper documentation containing the taker's name and permit number.

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- (5) NWCO permittees must follow all state and federal laws that apply to the taking of wildlife with the exception of season dates and bag limits except as otherwise provided in this section.
- (6) Only damage or nuisance complaints affecting humans and/or their property may be controlled. Complaints involving conflicts between two or more wildlife species are not valid nuisance wildlife complaints.
- (7) All wildlife taken under a NWCO permit shall be taken and disposed of in a manner to ensure safe and effective handling and/or euthanasia. Euthanasia of a captured animal is to be performed under the guidelines adopted by the American Veterinary Medicine Association.
- (8) Traps and other similar devices set by, ~~or under the direction of,~~ a NWCO shall be checked at least once every 24 hours and all animals removed. Traps must have the Operator's name and NWCO permit number attached.
- (9) The following are legal methods of control under a NWCO permit:
- (A) box or live trap;
 - (B) smooth-jawed single spring or double spring offset steel leg-hold traps with a jaw spread of no more than eight inches;
 - (C) ~~one bear body gripping~~ style traps less than size 330, except size 330 may be used for water sets for beavers only;
 - (D) shooting where permitted by law or by city ordinance; ~~and~~
 - (E) snares which shall have a locking device that prevents the loop from closing to a circumference less than ten (10) inches if the snare is set on or just above ground level. If the snare is set in an attic or similar situation there is no loop restriction; and
 - (F) enclosed trigger traps.
- (10) All trapping devices must be placed in a manner that will:
- (A) minimize the risk of non-target animals;
 - (B) minimize the risk to public and pets; and
 - (C) be out of the view of the general public.
 - (D) signs must be posted in conspicuous places in order to inform the public that traps are in use.
 - (E) signs must have minimum dimensions of 5" five inches by 8" eight inches and the wording "TRAPS" must be included and be conspicuous on the signs and printed in letters at least 2" two inches tall.
- (11) Shooting with firearms shall be subject to all state, county and municipal restrictions and ordinances. Night shooting is allowed for nuisance beavers only under the following conditions:
- (A) NWCO must notify the game warden(s) in the county where activity will occur twenty-four (24) hours prior to such activity;
 - (B) must be conducted in a safe manner to prevent injury to people, livestock and damage to personal property.
- (12) When relocation is authorized, the NWCO may have the wildlife in possession for no more than 24 hours unless specifically authorized by the Department.
- (13) Wildlife not euthanized, that but is relocated, shall be released ~~at least five (5) miles~~ outside any city limit but not more than one county distant from the capture site and must be within the state of Oklahoma.
- (14) Wildlife shall not be released on private land without written permission of the landowner or landowner designee.
- (15) Wildlife shall not be released on public land without first obtaining written permission from the governmental entity owning or administering the release property.
- (16) Captured wildlife that appears to be sick or diseased shall be euthanized rather than relocated. Burial or incineration of these carcasses is required.

[OAR Docket #14-962; filed 11-13-14]

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

1:2014-22.

EXECUTIVE ORDER 2014-22

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 8:00 a.m. to 5:00 p.m. on Tuesday, November 25, 2014, to honor Former Representative Barbara Staggs, who passed away on Saturday, November 22, 2014.

Barbara Staggs' passion for education showed through her career. She worked for the Muskogee school systems as a teacher, an assistant principal, and a principal. She then served as the Superintendent for Tahlequah public Schools. Staggs was the first woman elected to House District 14. Her service to our state will be missed.

This executive order shall be forwarded to the Department 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 24th day of November, 2014.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brian Bingman

ATTEST:

Luann McNaughten Hayes
Acting Assistant Secretary of State

[OAR Docket #14-977; filed 11-24-14]

