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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next regular legislative session after its promulgation, or on an earlier date specified by the agency, if not already superseded by a permanent rule or terminated through legislative action as described in 75 O.S., Section 253(H)(2).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 45. ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION CHAPTER 20. RETAIL SPIRIT STORES, MIXED BEVERAGE, CATERERS, SPECIAL EVENTS AND BOTTLE CLUBS

[OAR Docket #20-654]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 13. Curbside and Delivery Sales [NEW]

45:20-13-1. Licensees authorized to utilize curbside and delivery methods [NEW]

45:20-13-2. Signature required [NEW]

45:20-13-3. Maintaining records of delivery [NEW]

45:20-13-4. Delivery vehicle requirements [NEW]

45:20-13-5. Curbside and delivery hours [NEW]

45:20-13-6. Restriction on delivery area [NEW]

45:20-13-7. Invoice or receipt required on board [NEW]

AUTHORITY:

Oklahoma Alcoholic Beverage Control Act, 37A O.S. §1-101 et seq.;
Alcoholic Beverage Laws Enforcement Commission, 37A O.S. §1-107(2).

ADOPTION:

June 5, 2020

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

July 13, 2020

EXPIRATION:

Effective through September 14, 2021, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

This proposed emergency rule is necessary given the changes to occur through Senate Bill 1928. Senate Bill 1928 authorized certain retail deliveries of alcoholic beverages. The proposed rules are necessary to provide a framework for licensees to comply with the provisions of Senate Bill 1928.

GIST/ANALYSIS:

The gist of the rule changes is to provide a regulatory framework for retail delivery of alcoholic beverages to consumers.

CONTACT PERSON:

Steven Barker, Deputy Director and General Counsel, ABLE Commission,
3812 N. Santa Fe Avenue, Suite 200, Oklahoma City, OK 73118,
405-522-3050, steven.barker@able.ok.gov

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 13. CURBSIDE AND DELIVERY SALES

45:20-13-1. Licensees authorized to utilize curbside and delivery methods

(a) Small Brewers and Small Farm Winery license holders are authorized to sell alcoholic beverages they produce on the licensed premises at their curbside to consumers age 21 years or older in accordance with Title 37A O.S. §2-161.

(b) Retail Spirit license holders are authorized to sell sealed original containers of beer, wine, and spirits at their curbside or delivered to consumers age 21 years or older in accordance with Title 37A O.S. §2-161.

(c) Retail Beer, Retail Wine, Mixed Beverage, Caterer/Mixed Beverage, and Beer and Wine license holders are authorized to sell sealed original containers of beer or wine only at their curbside or delivered to consumers age 21 years or older in accordance with Title 37A O.S. §2-161.

(d) For purposes of this section, "curbside" shall mean the immediate outdoor area of the licensed premises that is owned, leased, or controlled by such licensee. Further, "delivery" shall mean the physical transportation of authorized alcoholic beverages to a consumer's physical location.

45:20-13-2. Signature required

A valid signature of the person 21 years of age or older receiving the alcoholic beverages shall be obtained at the time of each delivery.

45:20-13-3. Maintaining records of delivery

(a) All licensees authorized to engage in alcoholic beverage delivery to consumers provided for in Title 37A O.S. §2-161 shall maintain a record of each sale completed using delivery that includes the following information:

Emergency Adoptions

- (1) The purchaser's name, date of birth, and delivery location;
 - (2) The name and license number of the licensee's employee completing the delivery; and
 - (3) The signature receipt of the consumer receiving the delivery of alcoholic beverages.
- (b) These records shall be available for inspection by the ABLE Commission upon request, and shall be held for a period of twelve (12) months.

45:20-13-4. Delivery vehicle requirements

All vehicles used for retail delivery of alcoholic beverages shall have displayed on the outside of the vehicle, a sign in letters at least three (3) inches in height and one and one-half (1 1/2) inches in width, giving the name of the licensee and its Alcoholic Beverage Laws Enforcement Commission license number.

45:20-13-5. Curbside and delivery hours

Any licensee engaged in authorized curbside or delivery sales may do so during any such time the licensee is authorized to engage in the sale of alcoholic beverages. For all purposes including hours of operating delivery sales, all such delivery sales shall be considered completed at the time the alcoholic beverages being delivered are in the physical possession of the end consumer.

45:20-13-6. Restriction on delivery area

Any licensee engaged in authorized delivery sales may only do so within the county the licensed premise is located, and any immediately contiguous county sharing a county line border with the licensee's home county.

45:20-13-7. Invoice or receipt required on board

Any employee licensee making authorized retail alcohol deliveries on behalf of a licensed establishment must carry on board the delivery vehicle an invoice or physical receipt reflecting the following:

- (1) the name of the licensee selling the alcoholic beverages;
- (2) the name and location of the consumer purchasing the alcoholic beverages;
- (3) the date and time the transaction occurred; and
- (4) the price charged for the alcoholic beverages.

[OAR Docket #20-654; filed 7-21-20]

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

[OAR Docket #20-650]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-40 [AMENDED]
317:30-3-57 [AMENDED]
317:30-3-59 [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-42.16 [AMENDED]
317:30-5-42.17 [AMENDED]
Part 9. Long-Term Care Facilities
317:30-5-133.1 [AMENDED]
317:30-5-133.2 [REVOKED]
Part 17. Medical Suppliers
317:30-5-210 [AMENDED]
317:30-5-210.1 [AMENDED]
317:30-5-210.2 [AMENDED]
317:30-5-211.1 [AMENDED]
317:30-5-211.2 [AMENDED]
317:30-5-211.3 [AMENDED]
317:30-5-211.5 [AMENDED]
317:30-5-211.6 [AMENDED]
317:30-5-211.9 [REVOKED]
317:30-5-211.10 [AMENDED]
317:30-5-211.12 [AMENDED]
317:30-5-211.13 [AMENDED]
317:30-5-211.14 [AMENDED]
317:30-5-211.15 [AMENDED]
317:30-5-211.16 [AMENDED]
317:30-5-211.17 [AMENDED]
317:30-5-211.20 [NEW]
317:30-5-211.21 [NEW]
317:30-5-211.22 [NEW]
317:30-5-211.23 [NEW]
317:30-5-211.24 [NEW]
317:30-5-211.25 [NEW]
317:30-5-211.26 [NEW]
317:30-5-211.27 [NEW]
317:30-5-211.28 [NEW]
317:30-5-216 [REVOKED]
317:30-5-218 [AMENDED]
Part 61. Home Health Agencies
317:30-5-545 [AMENDED]
317:30-5-546 [AMENDED]
317:30-5-547 [AMENDED]
317:30-5-548 [AMENDED]
317:30-5-549 [REVOKED]
(Reference APA WF # 20-06A)

AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 6407 of the Affordable Care Act; Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015; CMS-2348-F Final Rule; Public Law 114-10; 42 Code of Federal Regulations (C.F.R.) § 440.70; and 42 C.F.R. § 440.120

ADOPTION:

June 30, 2020

EFFECTIVE:

Immediately upon Governor's approval or August 1, 2020, whichever is later.

APPROVED BY GOVERNOR:

July 13, 2020

EXPIRATION:

Effective through September 14, 2021, 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 requests emergency approval of rule revisions to medical supplier, home health agency, long-term care facility, hospitals, and general provider policies in order to avoid violation of federal law or regulation. Revisions will bring the agency into compliance with the Home Health final

rule which was effective July 1, 2016, and which changes medical supplies, equipment, and appliances (formerly called durable medical equipment) from an optional benefit to a mandatory benefit as well as expands the services required under this mandatory benefit.

GIST/ANALYSIS:

These emergency revisions are necessary in order to remove certain limits on coverage of DME and supplies, to change the place of service for which DME and supplies may be provided from a member's place of residence to any setting in which normal life activities take place except for inpatient settings, to require and define a face-to-face encounter between a member and a practitioner before the provision of DME and supplies, to require nursing facilities and intermediate care facilities for individuals with intellectual disabilities to provide certain DME and supplies without separate reimbursement from their monthly vendor payment, and to change the name of durable medical equipment to medical supplies, equipment, and appliances.

CONTACT PERSON:

Sandra Puebla, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F), AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR AUGUST 1, 2020, WHICHEVER IS LATER:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. ~~Home and Community-Based Services Waivers (HCBS) community-based services (HCBS) waivers for persons with intellectual disabilities or certain persons with related conditions~~

(a) **Introduction to HCBS waivers for persons with intellectual disabilities.** The Medicaid HCBS waiver programs are authorized per Section 1915(c) of the Social Security Act.

(1) ~~The~~ The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDS) operates HCBS waiver programs for persons with intellectual disabilities and certain persons with related conditions. The Oklahoma Health Care Authority (OHCA), is the State's Medicaid agency, retains and exercises administrative authority over all HCBS waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) HCBS waiver services:

(A) ~~complement~~ Complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) ~~are~~ Are only provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution;

(C) ~~are~~ Are not intended to replace other services and supports available to members; and

(D) ~~are~~ Are authorized based solely on current need.

(4) HCBS waiver services must be:

(A) ~~appropriate~~ Appropriate to the member's needs; and

(B) ~~included~~ Included in the member's ~~Individual Plan~~ individual plan (IP).

(i) The IP:

(I) ~~is~~ Is developed annually by the member's ~~Personal Support Team~~ personal support team, per Oklahoma Administrative Code (OAC) 340:100-5-52; and

(II) ~~contains~~ Contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized, per OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDS furnishes case management, targeted case management, and services to members as a Medicaid State Plan services, per Section 1915(g)(1) of the Social Security Act and per OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with an intellectual disability or related conditions.

(1) All providers, except pharmacy, ~~specialized medical supplies~~ and durable medical equipment (DME) providers must be reviewed by ~~DHS~~ OKDHS DDS. The review process verifies that:

(A) ~~the~~ The provider meets the licensure, certification or other standards specified in the approved HCBS waiver documents; and

(B) ~~organizations~~ Organizations that do not require licensure wanting to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet program standards in the review process are not approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP and arranged by the member's case manager.

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general ~~SoonerCare~~ SoonerCare coverage guidelines for the categorically needy:

(1) ~~Inpatient hospital~~ Inpatient-hospital services other than those provided in an institution for mental diseases (IMD).

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- (A) Adult coverage for ~~inpatient hospital~~inpatient-hospital stays as described at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-41.
- (B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.
- (2) Emergency department services.
- (3) Dialysis in an outpatient hospital or free standing dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected ~~outpatient surgical~~outpatient-surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).
- (6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified ~~hospital-based~~hospital-based facilities that are also qualified mental health clinics.
- (7) Rural health clinic (RHC) services and other ambulatory services furnished by ~~rural health clinic~~RHC.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity clinic services.
- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.
- (11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
- (12) ~~Nursing~~Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA ~~Child Health~~child-health services are outlined in OAC 317:30-3-65.2 through ~~317:30-3-65.4~~317:30-3-65.12.
- (A) ~~Child health screening examinations~~EPSDT screenings examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
- (B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
- (C) Immunizations.
- (D) Outpatient care.
- (E) Dental services as outlined in OAC 317:30-3-65.8.
- (F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
- (G) Hearing services as outlined in OAC 317:30-3-65.9.
- (H) Prescribed drugs.
- (I) ~~Outpatient psychological~~Outpatient-psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
- (J) ~~Inpatient psychiatric~~Inpatient-psychiatric services as outlined in OAC 317:30-5-95 through 317:30-5-97.
- (K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
- (L) ~~Inpatient hospital~~Inpatient-hospital services.
- (M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.
- (N) EPSDT services furnished in a qualified child health center.
- (14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.
- (15) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing long-term care~~ facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).
- (16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider ~~section~~Section for limitations to covered services for:
- (A) Podiatrists' services;
- (B) Optometrists' services;

- (C) Psychologists' services;
- (D) Certified ~~Registered~~ Nurse ~~Anesthetists~~ registered nurse anesthetists;
- (E) Certified ~~Nurse Midwives~~ nurse midwives;
- (F) Advanced ~~Practice Nurses~~ practice registered nurses; and
- (G) Anesthesiologist ~~Assistants~~ assistants.
- (17) Free-standing ambulatory surgery centers.
- (18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:
- (A) ~~unlimited~~ Unlimited medically necessary monthly prescriptions for:
- (i) ~~members~~ Members under the age of twenty-one (21) years; and
- (ii) ~~residents~~ Residents of ~~nursing~~ long-term care facilities or ICF/IID.
- (B) ~~seven~~ Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) ~~Home and Community Based Services Waivers (HCBS)~~ home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.
- (19) Rental and/or purchase of ~~durable medical equipment, medical supplies, equipment, and appliances~~.
- (20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.
- (21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).
- (22) ~~Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.~~ Orthotic and prosthetic devices for members under age twenty-one (21). For adults, orthotics and prosthetics are limited to breast prosthesis and support accessories. See OAC 317:30-5-210.1 and 317:30-5-211.13.
- (23) Standard medical supplies.
- (24) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
- (25) Blood and blood fractions for members when administered on an outpatient basis.
- (26) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
- (27) ~~Nursing~~ Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
- (28) Inpatient psychiatric facility admissions for members under twenty-one (21) are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
- (29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
- (30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.
- (31) ~~Nursing~~ Long-term care facility services for members under twenty-one (21) years of age.
- (32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a Registered Nurse (RN).
- (33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
- (34) HCBS for the intellectually disabled.
- (35) Home health services limited to thirty-six (36) visits per year and standard supplies for one (1) month in a twelve (12) month period. The visits are limited to any combination of ~~Registered Nurse~~ an RN and nurse aide visits, not to exceed thirty-six (36) per year.
- (36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:
- (A) ~~Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.~~
- (B) ~~To be prior authorized all procedures are reviewed based on appropriate medical criteria.~~
- (C) ~~To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.~~
- (D) ~~Finally, procedures considered experimental or investigational are not covered.~~
- (A) All transplantation services, except kidney and cornea, must be prior authorized;
- (B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;
- (C) All organ transplants must be performed at a Medicare approved transplantation center;
- (D) Procedures considered experimental or investigational are not covered; and
- (E) Donor search and procurement services are covered for transplants consistent with the methods

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used by the Medicare program for organ acquisition costs.

- (37) HCBS for intellectually disabled members who were determined to be inappropriately placed in a ~~nursing~~long-term care facility (Alternative Disposition Plan - ADP).
- (38) Case management services for the chronically and/or severely mentally ill.
- (39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
- (40) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
- (41) Early intervention services for children ages zero (0) to three (3).
- (42) Residential behavior management in therapeutic foster care setting.
- (43) Birthing center services.
- (44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
- (45) HCBS for aged or physically disabled members.
- (46) Outpatient ambulatory services for members infected with tuberculosis.
- (47) Smoking and tobacco use cessation counseling for children and adults.
- (48) Services delivered to American Indians/Alaskan Natives (AI/AN) in I/T/Us Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
- (49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

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

The following are excluded from SoonerCare coverage for adults:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Services or any expense incurred for cosmetic surgery.
- (3) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
- (4) Refractions and visual aids.
- (5) Pre-operative care within ~~24~~twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
- (6) Sterilization of members who are under ~~24~~twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

- (7) Non-therapeutic hysterectomies.
- (8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest.—~~(Refer to OAC 317:30-5-6 or 317:30-5-50.)~~
- (9) Medical services considered experimental or investigational.
- (10) Services of a ~~Certified Surgical Assistant~~certified surgical assistant.
- (11) Services of a ~~Chiropractor~~chiropractor. Payment is made for ~~Chiropractor~~chiropractor services on ~~Crossover~~crossover claims for coinsurance and/or deductible only.
- (12) Services of an independent licensed ~~Physical~~physical and/or ~~Occupational Therapist~~occupational therapist.
- (13) Services of a ~~Psychologist~~psychologist.
- (14) Services of an independent licensed ~~Speech and Hearing Therapist~~speech and hearing therapist.
- (15) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
- (16) Payment for more than ~~two~~nursing~~two~~ (2) long-term care facility visits per month.
- (17) More than one (1) inpatient visit per day per physician.
- (18) Payment for removal of benign skin lesions.
- (19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- (20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in ~~OHCA~~the Oklahoma Health Care Authority (OHCA) rules.
- (22) Mileage.
- (23) A routine hospital visit on the date of discharge unless the member expired.
- (24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- (25) Inpatient chemical dependency treatment.
- (26) Fertility treatment.
- (27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
- ~~(28) Sleep studies.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the Authority's Medical Programs, SoonerCare program.

(b) **Home health care.** ~~Hospital-based~~ Hospital-based home health providers must be Medicare certified and have a current Home Health Agency contract with the ~~OHCA~~ Oklahoma Health Care Authority (OHCA). For home health services, a qualified provider must conduct and document a face-to-face encounter with the member in accordance with provisions of ~~42 CFR §440.70.~~ 42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Oklahoma Administrative Code (OAC) 317:30-5-546 and OAC 317:30-5-547 for additional policy related to coverage and reimbursement for home health care services.

(1) ~~Payment is made for home health services provided in a member's residence to all categorically needy individuals.~~

(2) ~~Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.~~

(3) ~~Payment is made for standard medical supplies.~~

(4) ~~Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.~~

(5) ~~Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro spinal orthosis systems (ESO).~~

(6) ~~Payment may be made to home health agencies for prosthetic devices.~~

(A) ~~Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.~~

(B) ~~Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.~~

(C) ~~Sterile tracheotomy trays are covered.~~

(D) ~~Payment is made for colostomy and urostomy bags and accessories.~~

(E) ~~Payment is made for hyperalimentation, including supplements, supplies and equipment rental on behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.~~

(F) ~~Payment is made for ventilator equipment and supplies when prior authorized.~~

(G) ~~Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.~~

(c) ~~**Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. 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 death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.~~

(1) ~~Payment is made for home-based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal 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 providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.~~

(2) ~~Hospice care is available for two initial 90 day periods and an unlimited number of subsequent 60 day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter, and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services.~~

(3) ~~Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.~~

(4) ~~Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.~~

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC Oklahoma Administrative Code]

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(OAC)317:30-5-2(a)(2)] the following are excluded from coverage:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
- (3) Reversal of sterilization procedures for the purposes of conception are not covered.
- (4) Medical services considered experimental or investigational.
- (5) Payment for removal of benign skin lesions for adults.
- (6) Visual aids.
- (7) Charges incurred while the member is in a skilled nursing or swing bed.
- (8) ~~Sleep studies for adults.~~

PART 9. LONG-TERM CARE FACILITIES

317:30-5-133.1. Routine services

(a) ~~Nursing~~Long-term care facility care includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by SoonerCare residents. Charges for routine services may not be made to resident's personal funds or to resident family members, guardians, or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and the SoonerCare resident's applied income, or spend down amount.

(b) The ~~OHCA~~Oklahoma Health Care Authority (OHCA) will review the listing periodically for additions or deletions, as indicated. Routine services are member specific and provided in accordance with standard medical care. Routine services include, but are not limited to:

- (1) Regular room.
- (2) Dietary ~~Services~~services:
 - (A) ~~regular~~Regular diets;
 - (B) ~~special~~Special diets;
 - (C) ~~salt~~Salt and sugar substitutes;
 - (D) ~~supplemental~~Supplemental feedings;
 - (E) ~~special~~Special dietary preparations;
 - (F) ~~equipment~~Equipment required for preparing and dispensing tube and oral feedings; and
 - (G) ~~special~~Special feeding devices (furnished or arranged for).
- (3) Medically related social services to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed).
- (4) Personal services - personal laundry services for residents (does not include dry cleaning).

(5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:

- (A) ~~shampoo~~Shampoo, comb, and brush;
 - (B) ~~bath~~Bath soap;
 - (C) ~~disinfecting~~Disinfecting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;
 - (D) ~~razor~~Razor and/or shaving cream;
 - (E) ~~nail~~Nail hygiene services; and
 - (F) ~~sanitary~~Sanitary napkins, douche supplies, perineal irrigation equipment, solutions, and disposable douches.
- (6) Routine oral hygiene items, including:
- (A) ~~toothbrushes~~Toothbrushes;
 - (B) ~~toothpaste~~Toothpaste;
 - (C) ~~dental~~Dental floss;
 - (D) ~~lemon~~Lemon glycerin swabs or equivalent products; and
 - (E) ~~denture~~Denture cleaners, denture adhesives, and containers for dental prosthetic appliances such as dentures and partial dentures.
- (7) Necessary items furnished routinely as needed to all members, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.
- (8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors and, first aid supplies, including small bandages, ointments and preparations for minor cuts and abrasions, and enema supplies, disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.
- (9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, ~~nursing~~long-term care facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.
- (A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the member. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;
 - (B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;
 - (C) If the member, family, or other responsible party (excluding the ~~nursing~~long-term care facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident

needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the member, family member, or responsible party indicating his or her desired preference, as well as the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument.

(10) The facility will furnish or obtain any necessary equipment to meet the needs of the member upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs and/or geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pads, ice bags, sand bags, traction equipment, IV stands, etc.

(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other third party payer.

(12) Supplies required for dispensing medications, including needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.

(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood glucose meters and test strips, etc.

(14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.

(A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;

(B) If the resident or the family requests the use of disposable diapers and they are not prescribed or consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense.

(15) ~~Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity. Members in long-term care facilities requiring oxygen will be serviced by oxygen kept on hand by the long-term care facility as part of the per diem rate.~~

(16) Other physician ordered equipment to adequately care for the member and in accordance with standard patient care, ~~including infusion pumps and supplies, and nebulizers and supplies, etc.~~

(17) Dentures and ~~Related Services~~ and related services. Payment for the cost of dentures and related services is included in the daily rate for routine services. The projected schedule for routine denture services must be documented on the Admission Plan of Care and on the

Annual Plan of Care. The medical records must also contain documentation of steps taken to obtain the services. When the provision of denture services is medically appropriate, the ~~nursing long-term care~~ facility must make timely arrangements for the provision of these services by licensed dentists. In the event denture services are not medically appropriate, the treatment plan must reflect the reason the services are not considered appropriate, e.g., the member is unable to ingest solid nutrition or is comatose, etc. When the need for dentures is identified, one (1) set of complete dentures or partial dentures and one (1) dental examination is considered medically appropriate every three (3) years. One (1) rebase and/or one (1) reline is considered appropriate every three (3) years. It is the responsibility of the ~~nursing long-term care~~ facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. The ~~nursing long-term care~~ facility cannot set up payment limits which result in barriers to obtaining denture services. However, the ~~nursing long-term care~~ facility may restrict the providers of denture services to providers who have entered into payment arrangements with the facility. The facility may also choose to purchase a private insurance dental coverage product for each SoonerCare member. At a minimum, the policy must cover all denture services included in routine services. The member cannot be expected to pay any co-payments and/or deductibles. If a difference of opinion occurs between the ~~nursing long-term care~~ facility, member, and/or family regarding the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

(18) Vision ~~Services~~ services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, glaucoma, conjunctivitis, corneal ulcers, iritis, etc. Treatment of known eye disease is a benefit of the member's medical plan. The projected schedule for routine vision care must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical record must contain documentation of the steps that have been taken to access the service. When vision services are not appropriate, documentation of why vision services are not medically appropriate must be included in the treatment plan. For example, the member is comatose, unresponsive, blind, etc. Nursing Home providers may contract with individual eye care providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

(A) The following minimum level of services must be included:

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(i) Individuals ~~21~~twenty-one (21) to ~~40~~forty (40) years of age are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~36~~thirty-six (36) months ~~{[three (3) years]}~~.

(ii) Individuals ~~41~~forty-one (41) to ~~64~~sixty-four (64) years of age are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~24~~twenty-four (24) months ~~(2 years)~~[two (2) years].

(iii) Individuals ~~65~~sixty-five (65) years of age or older are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~12~~twelve (12) months (yearly).

(B) It is the responsibility of the nursinglong-term care facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, nursinglong-term care facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the nursinglong-term care facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide ~~Non-Emergency Transportation~~non-emergency transportation (NET). Please refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a nursinglong-term care facility. ~~And; and~~

(20) Influenza and pneumococcal vaccinations.

317:30-5-133.2. Ancillary services [REVOKED]

~~(a) Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:~~

~~(1) Services requiring prior authorization:~~

~~(A) External breast prosthesis and support accessories.~~

~~(B) Ventilators and supplies.~~

~~(C) Total Parenteral Nutrition (TPN), and supplies.~~

~~(D) Custom seating for wheelchairs.~~

~~(2) Services not requiring prior authorization:~~

~~(A) Permanent indwelling or male external catheters and catheter accessories.~~

~~(B) Colostomy and urostomy supplies.~~

~~(C) Tracheostomy supplies.~~

~~(D) Catheters and catheter accessories.~~

~~(E) Oxygen and oxygen concentrators.~~

~~(i) PRN Oxygen. Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) Billing for Medicare eligible members. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~

~~(b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:~~

~~(1) Diapers.~~

~~(2) Underpads.~~

~~(3) Medicine cups.~~

~~(4) Eating utensils.~~

~~(5) Personal comfort items.~~

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority (OHCA). The supplier must comply with all applicable ~~State and Federal~~state and federal laws. Effective January 1, 2011, all suppliers of ~~durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)~~medical supplies, equipment, and appliances must be accredited by a Medicare deemed accreditation organization for quality standards for ~~DMEPOS~~durable medical equipment (DME) suppliers in order to bill the SoonerCare program. ~~For coverage of orthotics and prosthetics, refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13.~~ OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all ~~DMEPOS~~DME providers must meet the following criteria:

(1) ~~DMEPOS~~DME providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a ~~DMEPOS~~DME provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state ~~DMEPOS~~DME providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) ~~DMEPOS~~DME providers are required to comply with Medicare ~~DMEPOS~~DME Supplier Standards for ~~DMEPOS~~medical supplies, equipment, and appliances provided to SoonerCare members, except the requirement

to meet surety bond requirements, as specified in 42 C.F.R. 424.57(c).

(3) ~~Complex Rehabilitation Technology~~ rehabilitation technology (CRT) suppliers are considered ~~DME-POS~~ DME providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

- (A) Is accredited by a recognized accrediting organization as a supplier of CRT;
- (B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;
- (C) Employs as a W-2 employee at least one (1) qualified CRT professional, also known as assistive technology professional, for each location to:
 - (i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;
 - (ii) Participate in selecting appropriate CRT items for such needs and capacities; and
 - (iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.
- (D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;
- (E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and
- (F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

317:30-5-210.1. Coverage for adults

~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for adults is specified in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. Coverage of medical supplies, equipment, and appliances for adults complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC 317:30-5-211.19. Orthotics and prosthetics are not a covered service for adults with the exception of breast prosthetics and support accessories (Refer to OAC 317:30-5-211.13).~~

317:30-5-210.2. Coverage for children

(a) **Coverage.** ~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only: Medical supplies, equipment, and appliances are covered for children. In addition, orthotics and prosthetics are covered items for children only, except as specified in OAC 317:30-5-211.3.~~

- (1) ~~Orthotics and prosthetics.~~
- (2) ~~Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the~~

~~member's condition would deteriorate to the point of severe malnutrition.~~

- (A) ~~Enteral nutrition must be prior authorized. PA requests must include:~~
 - (i) ~~the member's diagnosis;~~
 - (ii) ~~the impairment that prevents adequate nutrition by conventional means;~~
 - (iii) ~~the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;~~
 - (iv) ~~the percentage of the member's average daily nutrition taken by mouth and by tube; and~~
 - (v) ~~prescribed daily caloric intake.~~
- (B) ~~Enteral nutrition products that are administered orally and related supplies are not covered.~~
- (3) ~~Continuous positive airway pressure devices (CPAP).~~

(b) ~~EPSDT. Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.~~ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, are covered regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's State Plan.

(c) **Medical necessity.** Federal regulations require ~~OHCA~~ the Oklahoma Health Care Authority (OHCA) to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

317:30-5-211.1. Definitions

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

"Activities of daily living-basic" means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"Activities of daily living-instrumental" means activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).

"Adaptive equipment" means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for Individuals with Intellectual Disabilities (IFC/IID) with independence and safety.

"Basic activities of daily living" means a series of activities performed on a day-to-day basis that are necessary to care

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~~for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).~~

~~"Capped rental" means monthly payments for the use of the Durable Medical Equipment (DME) medical supplies, equipment, and appliances for a limited period of time not to exceed 13thirteen (13) months. Items are considered purchased and owned by the Oklahoma Health Care Authority (OHCA) after 13thirteen (13) months of continuous rental.~~

~~"Certificate of medical necessity (CMN)" means a certificate which is required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. The physician's certification CMN must include the member's diagnosis, the reason the equipment is required, and the physician's, non-physician provider's (NPP's), or dentist's estimate, in months, of the duration of its need.~~

~~"Complex needs patient" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.~~

~~"Complex rehabilitation technology" means medically necessary durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a complex needs patientpatient with complex needs. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers.~~

~~"Customized DMEequipment and/or appliances" means items of DMEequipment and/or appliances which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician or other qualified medical professional. For instance, a wheelchair would be considered "customized" if it has been:~~

- ~~(A) measuredMeasured, fitted, or adapted in consideration of the member's body size, disability, period of need, or intended use;~~
- ~~(B) assembledAssembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and~~
- ~~(C) intendedIntended for an individual member's use in accordance with instructions from the member's physician.~~

~~"Durable medical equipment (DME)Equipment and/or appliances" means equipment that can withstand repeated use (e.g., a type of item that could normally be rented), is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting, including the home or workplaceitems that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, can be reusable or removable, and are suitable~~

~~for use in any setting in which normal life activities take place other than a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Refer to 42 Code of Federal Regulations (C.F.R.) 440.70(b).~~

~~"Face-to-face encounter" means a patient visit in which a practitioner, as defined by 42 C.F.R. 440.70(f), completes a face-to-face assessment related to the primary reason the beneficiary requires durable medical equipment. The face-to-face encounter must occur no more than six (6) months prior to the start of services. The ordering physician must document the face-to-face encounter, including the practitioner who conducted the encounter and the date of the encounter. Clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record. The face-to-face encounter may occur through telehealth.~~

~~"Instrumental activities of daily living" means activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).~~

~~"Invoice" means a document that provides the following information when applicable: the description of product, quantity, quantity in box, purchase price, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.~~

~~"Medical supplies" means an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers.health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies do not include skin care creams, cleansers, surgical supplies, or medical or surgical equipment.~~

~~"OHCA CMN" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this chapterChapter. The physician'scertificationCMN must include the member's diagnosis, the reason equipment is required, and the physician's, NPP's, or dentist's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one (1) has not been established by CMS.~~

~~"Orthotics" means an item used for the correction or prevention of skeletal deformities;a device used to support, align, prevent or correct deformities, protect a body function, improve the function of movable body parts or to assist a dysfunctional joint.~~

~~"Patient with complex needs" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.~~

~~"Prosthetic devices"~~ **"Prosthetics"** means a ~~replacement, corrective, or supportive device (including repair and replacement parts of the same) worn on or in the body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body~~ an artificial substitute which replaces all or part of a body organ or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

"Provider" refers to the treating provider and must be a physician [Medical Doctor (MD), or Doctor of Osteopathy, (DO)], a NPP [Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)], or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)].

~~"Qualified complex rehabilitation technology professional"~~ means an individual who is certified as an Assistive Technology Professional (ATP) by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

317:30-5-211.2. Medical necessity

(a) **Coverage.** Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, in accordance with state and federal Medicaid law, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-1(f). The member's diagnosis must warrant the type of equipment or supply being purchased or rented. Items that are used for the following are not a benefit to a member of any age:

- (1) Routine personal hygiene;
- (2) Education;
- (3) Exercise;
- (4) Convenience, safety, or restraint of the member, or his or her family or caregiver;
- (5) Participation in sports; and/or
- (6) Cosmetic purposes.

(b) **Ordering requirements.** All medical supplies, equipment, and appliances as defined by 42 Code of Federal Regulations (C.F.R.) § 440.70 (b)(3) and OAC 317:30-5-211.1, nursing services, and home health aide services provided by a home health agency, must be ordered by a physician as part of a written plan of care.

(1) The plan of care must be reviewed in accordance with 42 C.F.R. § 440.70. Medical supplies, equipment, and appliances must be reviewed annually by the ordering physician. Nursing services and home health aide services provided by a home health agency must be reviewed every sixty (60) days by the ordering physician.

(2) A face-to-face encounter must occur and be documented, in accordance with 42 C.F.R. § 440.70 and OAC 317:30-5-211.1.

(bc) **Prescription requirements.** All ~~DME~~ prosthetics and orthotics, as those terms are defined by 42 C.F.R. § 440.120 and OAC 317:30-5-211.1, except for hearing aid batteries and equipment repairs with a cost per item of less than \$250.00\$1,000.00 total parts and labor—and hearing aid batteries, require a prescription signed by a physician, a

physician assistant, or an advanced practice nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one (1) year from the date written. The prescription must include the following information:

- (1) ~~date of the order;~~
- (2) ~~name and address of the prescriber;~~
- (3) ~~name and address of the member;~~
- (4) ~~name or description and quantity of the prescribed item;~~
- (5) diagnosis for the item requested;
- (6) directions for use of the prescribed item; and
- (7) prescriber's signature.
- (1) The member's name;
- (2) The prescribing practitioner's name;
- (3) The date of the prescription;
- (4) All items, options, or additional features that are separately billed. The description can be either a narrative description (e.g. lightweight wheelchair base), a Health-care Common Procedure Coding System (HCPCS) code, a HCPCS code narrative, or a brand name/model number; and
- (5) The prescribing practitioner's signature and signature date.

(ed) **Certificate of medical necessity (CMN).** For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician, non-physician practitioner, or dentist. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be ~~faxed,~~ copied, faxed copy, electronic copy, or the original hardcopy.

(de) **Place of service.**

(1) ~~OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility.~~ The Oklahoma Health Care Authority (OHCA) covers medical supplies, equipment, and appliances for use in the member's place of residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) ~~For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.~~ For members residing in a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board, medical supplies, equipment, and appliances are considered part of the facility's per diem rate.

(f) **Contracting requirements.** Per 42 C.F.R. 455.410(b), medical supplies, equipment, and appliances may only be ordered or prescribed by a SoonerCare contracted provider.

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317:30-5-211.3. Prior authorization (PA)

(a) **General.** Prior authorization is the electronic or written authorization issued by ~~OHCA—the Oklahoma Health Care Authority (OHCA)~~ to a provider prior to the provision of a service. Providers should obtain a PA before providing services.

(b) **Requirements.** Billing must follow correct coding guidelines as promulgated by CMS or per uniquely and publicly promulgated OHCA guidelines. ~~DME~~Medical supplies, equipment, and appliances claims must include the most appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code as assigned by the Medicare Pricing, Data, Analysis, and Coding (PDAC) or its successor. Authorizations for services not properly coded will be denied. **The following services require prior authorization (PA):**

- (1) services that exceed quantity/frequency limits;
- (2) medical need for an item that is beyond OHCA's standards of coverage;
- (3) use of a Not Otherwise Classified (NOC) code or miscellaneous codes;
- (4) services for which a less costly alternative may exist; and
- (5) procedures indicating that a PA is required on the OHCA fee schedule.

(c) **Prior authorization (PA) requests.** ~~Refer to OAC 317:30-5-216.~~

(1) **PA requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring a PA. Also refer to OAC 317:30-3-31.

(A) **Required forms.** All required forms are available on the OHCA website.

(B) **Certificate of medical necessity (CMN).** The prescribing physician, non-physician practitioner (NPP), or dentist must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's physician, NPP, or dentist may sign the CMN. By signing the CMN, the physician, NPP, or dentist is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the PA request.

(2) **Submitting PA requests.** Contact information for submitting PA requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA website.

(3) **PA review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(4) **PA decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review.

(5) **PA does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(6) **PA of manually-priced items.** Manually-priced items must be prior authorized. For reimbursement of manually priced items, see OAC 317:30-5-218.

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) **Repairs.** Repairs to equipment that either the Oklahoma Health Care Authority or a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment cannot be made for the amount in excess. Repairs of rented equipment are not covered.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. ~~DMEPOS~~DME suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state, and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the ~~13th~~thirteenth (13th) month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

(1) ~~If a capped rental item of equipment has been in continuous use~~If equipment that has met the capped rental period and has been in continued use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful lifetime for capped rental equipment cannot be less than five (5) years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code that represents the item or part being ~~replaced~~replaced along with a pricing modifier and replacement modifier. If a part that has not been

assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

(d) **Delivery.** ~~DMEPOS~~Medical supplies, equipment, and appliance products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept ~~DMEPOS~~medical supplies, equipment, and appliance products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any ~~DMEPOS~~medical supplies, equipment, and appliance product exceeding a member's expected utilization. The reordering or refilling of ~~DMEPOS~~medical supplies, equipment, and appliance products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of ~~DMEPOS~~medical supplies, equipment, and appliance products:

- (1) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the member regarding refills should take place no sooner than ~~seven (7)~~ seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the ~~DMEPOS~~medical supplies, equipment, and appliance product no sooner than ~~five (5)~~ five (5) days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product. Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the ~~DMEPOS~~medical supplies, equipment, and appliance product was refilled in accordance with this section.
- (2) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the ~~DMEPOS~~medical supplies, equipment, and appliance product was delivered via the mail. Reimbursement for ~~DMEPOS~~medical supplies, equipment, and appliance products supplied and delivered via mail may be at a reduced rate.
- (3) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

317:30-5-211.6. General documentation requirements

(a) Section 1833(e) of the Social Security Act precludes payment to any provider of service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" [~~42 U.S.S. Section 13951(e)~~][42 United States Code (U.S.C. Section 13951(e))]. The member's medical records will reflect the need for the care provided. The member's medical records should include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be provided for prior authorization requests and available to the ~~OHCA~~Oklahoma Health Care Authority or its designated agent upon request.

(b) Payment is made for durable medical equipment as set forth in this section when a face-to-face encounter has occurred in accordance with provisions of 42 Code of Federal Regulations (C.F.R.) § 440.70 and Oklahoma Administrative Code 317:30-5-211.1.

317:30-5-211.9. Adaptive equipment [REVOKED]

(a) ~~Residents of ICF/IID facilities.~~ Payment is made for customized adaptive equipment for persons residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). This means customized equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc., would not be considered customized adaptive equipment. All customized adaptive equipment must be prescribed by a physician and requires prior authorization.

(b) ~~Members in home and community-based waivers.~~ Refer to OAC 317:40-5-100.

317:30-5-211.10. ~~Durable medical equipment (DME)~~Medical supplies, equipment, and appliances

(a) ~~DME~~Medical supplies, equipment, and appliances. DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment, and other qualifying items when acquired from a ~~contracted DME provider.~~ See the definition for medical supplies, equipment, and appliances at Oklahoma Administrative Code 317:30-5-211.1.

(b) **Certificate of medical necessity (CMN).** Certain items of ~~DME~~medical supplies, equipment, and appliances require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include, but are not limited to:

- (1) hospital beds;
 - (2) support surfaces;
 - (3) patient lift devices;
 - (4) external infusions pumps;
 - (5) enteral and parenteral nutrition;
 - (6) Oxygen and oxygen related products; and
 - (7) pneumatic compression devices.
- (1) External infusion pumps;
 - (2) Hospital beds;
 - (3) Oxygen and oxygen related products;

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- (4) Pneumatic compression devices;
 - (5) Support surfaces;
 - (6) Enteral and parenteral nutrition; and
 - (7) Osteogenesis stimulator.
- (c) ~~Prior authorization.~~ Rental. Several medical supplies, equipment, and appliance products are classified as either a capped rental or a continuous rental. Payment for a capped rental is capped at thirteen (13) months and a continuous rental is paid monthly for as long as it is medically necessary. Both require documentation showing that the product is medically necessary.
- (1) ~~Rental.~~ Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record, signed by the physician, and attached to the PA.
 - (2) ~~Purchase.~~ Equipment may be purchased when a member requires the equipment for an extended period of time. During the prior authorization review, the OHCA may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.
- (d) Purchase. Medical supplies, equipment, and appliances may be purchased when a member requires the product for an extended period of time. During the prior authorization review, the Oklahoma Health Care Authority (OHCA) may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted.
- (~~e~~) Backup equipment. Backup equipment is considered part of the rental cost and is not a covered service without prior authorization.
- (~~f~~) Home modification. Equipment used for home modification is not a covered service. Home modifications that require permanent installation are not covered services as they are not removable and therefore do not meet the definition of medical supplies, equipment, and appliances per 42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Title 317, Chapters 40 and 50 for home modifications covered under Home and Community Based Services Waivers including the ADvantage Waiver.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc., that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

- (1) Stationary oxygen systems and portable oxygen systems are covered items for members residing in their home or in a nursing facility and in any setting in which normal life activities take place except for a hospital,

long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. ~~Portable oxygen contents are not covered for adults.~~ Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When four (4) or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% ~~one hundred and fifty percent (150%)~~ of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.13. ~~Prosthetics and orthotics~~ Orthotics and prosthetics

Coverage of prosthetics for adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate medical provider and as specified in this section are covered items for adults. There is no coverage of orthotics for adults.

- (1) ~~Home dialysis.~~ Equipment and supplies are covered items for members receiving home dialysis treatments only.
- (2) ~~Nerve stimulators.~~ Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.
- (3) ~~Breast prosthesis, bras, and prosthetic garments.~~ (A) Payment is limited to:
 - (i) one prosthetic garment with mastectomy form every 12 months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;
 - (ii) two mastectomy bras per year; and
 - (iii) one silicone or equal breast prosthetic per side every 24 months; or
 - (iv) one foam prosthetic per side every six months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same 12 month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:
 - (i) lost;
 - (ii) irreparably damaged (other than ordinary wear and tear); or

(iii) ~~the member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.~~

~~(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.~~

~~(4) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.~~

(a) Orthotics and prosthetics are classified as an optional benefit by the Center for Medicare and Medicaid Services (CMS) and are administered as per 42 C.F.R. § 440.120. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

(b) There is no coverage of orthotics for adults.

(c) Coverage of prosthetics for adults is limited to one (1) breast prosthesis and support accessories and two (2) prosthetic devices inserted during surgery.

(1) **Breast prosthesis and support accessories.**

(A) Payment is limited to:

(i) One (1) prosthetic garment with mastectomy form every twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) Two (2) mastectomy bras per year; and

(iii) One (1) silicone or equal breast prosthetic per side every twenty-four (24) months; or

(iv) One (1) foam prosthetic per side every six (6) months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) Lost;

(ii) Irreparably damaged (other than ordinary wear and tear); or

(iii) The member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

(2) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

317:30-5-211.14. Nutritional support

(a) **Enteral nutrition.** Enteral nutrition administered only via gravity, syringe, or pump is covered for children and adults at home. Refer to pharmacy policy related to coverage of food supplements at Oklahoma Administrative Code (OAC) 317:30-5-72.1. For enteral nutrition authorization guidelines, see OAC 317:30-5-211.20.

(a**b**) **Parenteral nutrition.** The member must require intravenous feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) medical staff.

(c) **Long-term care facility enteral and parenteral nutrition.** Enteral and parenteral nutrition products supplied to long-term care facility residents will be included in the long-term care facility per diem rate.

~~(b~~d) **Prior authorization**Claim submission requirements.

A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary. The ordering physician is expected to see the member within ~~30~~thirty (30) days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

~~(e) **Enteral formulas.** Enteral formulas are covered for children only. See OAC 317:30-5-210.2.~~

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317:30-5-211.15. ~~Supplies~~Medical Supplies

The ~~OHCA~~Oklahoma Health Care Authority (OHCA) provides coverage for medically necessary supplies that are prescribed by the appropriate medical provider and meet the ~~special requirements below;~~member's specific needs. Medical supplies include, but are not limited to, IV therapy supplies, diabetic supplies, catheters, colostomy and urostomy supplies, and incontinence supplies.

- ~~(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.~~
- ~~(2) **Diabetic supplies.** Glucose test strips and lancets are covered when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse. Testing supplies may be limited based on insulin use or type of diabetes. Prior authorization may be required for supplies beyond the standard allowance.~~
- ~~(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.~~
- ~~(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.~~

317:30-5-211.16. Coverage for nursinglong-term care facility residents

~~(a) For residents in a nursinglong-term care facility, most DMEPOS medical supplies, equipment and appliances are considered part of included in the facility's per diem rate. Prosthetics and orthotics are paid separately from the per diem rate. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13 for coverage. The following are not included in the per diem rate and may be billed by the appropriate medical supplier:~~

- ~~(1) Services requiring prior authorization:~~
 - ~~(A) ventilators and supplies;~~
 - ~~(B) total parenteral nutrition (TPN), and supplies;~~
 - ~~(C) custom seating for wheelchairs; and~~
 - ~~(D) external breast prosthesis and support accessories.~~
- ~~(2) Services not requiring prior authorization:~~
 - ~~(A) permanent indwelling or male external catheters and catheter accessories;~~
 - ~~(B) colostomy and urostomy supplies;~~
 - ~~(C) tracheostomy supplies;~~
 - ~~(D) catheters and catheter accessories;~~
 - ~~(E) oxygen and oxygen concentrators.~~
 - ~~(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~
 - ~~(ii) **Billing for Medicare eligible nursing home members.** Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain~~

~~a denial from Medicare prior to filing the claim with OHCA.~~

- ~~(b) Items not covered include but are not limited to:~~
 - ~~(1) diapers;~~
 - ~~(2) underpads;~~
 - ~~(3) medicine cups;~~
 - ~~(4) eating utensils; and~~
 - ~~(5) personal comfort items.~~

317:30-5-211.17. Wheelchairs

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Assistive technology professional" or "ATP"** means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices. All ATPs are required to be credentialed by Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(2) **"Custom seating system"** means a wheelchair seating system which is individually made for a member using a plaster model of the member, a computer generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or

(B) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

(3) **"RESNA"** means the Rehabilitation Engineering and Assistive Technology Society of North America.

(4) **"Specialty evaluation"** means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity, pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-211.2, is required for a wheelchair to be covered and reimbursed by SoonerCare. Only one (1) wheelchair is covered as medically necessary during its reasonable useful lifetime, unless the member's documented medical condition indicates the current wheelchair no longer meets the member's medical need. Backup wheelchairs are not covered items.

(c) **Prior authorization.** Prior authorization, pursuant to OAC 317:30-5-211.3, is required for selected wheelchairs to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) Wheelchair parts, accessories, and/or modifications that are distinctly and separately requested and priced from the original wheelchair request may require prior authorization.

(3) The ~~OHCA~~Oklahoma Health Care Authority will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) Coverage and limitations.

~~(1) For a member who resides in a personal residence, assisted living facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or long term care facility, the following criteria must be met for the authorization to purchase a wheelchair.~~

~~(A) The member must have a prescription signed by a physician, a physician assistant, or an advanced registered nurse practitioner.~~

~~(B) The member must meet the requirements for medical necessity as determined and approved by the OHCA.~~

~~(C) The member must either have:~~

~~(i) a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist, occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and that documents the medical necessity for the wheelchair and its special features; or~~

~~(ii) a wheelchair provided by a supplier that employs a RESNA certified assistive technology professional who specializes in wheelchairs and who has direct, in person involvement in the wheelchair selection for the member.~~

~~(2) For members who reside in a long term care facility or ICF/IID, only custom seating systems for wheelchairs are eligible for direct reimbursement to DME providers. For members who reside in a long-term care facility or intermediate care facility for individuals with intellectual disabilities, All standard manual and power wheelchairs are the responsibility of the facility and are considered part of the facility's per diem rate. Repairs and maintenance, except for custom seating systems, are not covered items for wheelchairs and are considered part of the facility's per diem rate.~~

(e) Rental, repairs, maintenance, and delivery. Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) Documentation.

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than ~~90~~ninety (90) days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed, and dated by the medical professional who evaluated the member or the ATP who was involved in the wheelchair selection for the member.

317:30-5-211.20. Enteral nutrition

(a) Enteral Nutrition. Enteral nutrition is the delivery of nutrients directly into the stomach, duodenum or jejunum.

(b) Medical necessity. Enteral nutrition supplies must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by medical providers for enteral nutrition supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) Documentation. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

- (1) Diagnosis;
- (2) Certificate of Medical Necessity (CMN);
- (3) Ratio data;
- (4) Route;
- (5) Caloric intake; and
- (6) Prescription.
- (7) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

(1) Extension sets and Farrell bags are not covered when requested separately from the supply kits;

(2) Enteral nutrition for individuals in long-term care facilities is not separately reimbursed as this is included in the per diem rate.

(e) Non-covered items. The following are non-covered items:

- (1) Orally administered enteral products and/or related supplies;
- (2) Formulas that do not require a prescription unless administered by tube;
- (3) Food thickeners, human breast milk, and infant formula;
- (4) Pudding and food bars; and
- (5) Nursing services to administer or monitor the feedings of enteral nutrition.

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317:30-5-211.21. Incontinence supplies

(a) **Incontinence supplies and services.** Incontinence supplies and services are those supplies that are used to alleviate or prevent skin breakdown or excoriation associated with incontinence.

(b) **Medical necessity.** Incontinence supplies must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for incontinence supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

- (1) A signed provider prescription specifying the requested item;
- (2) A documented diagnosis of an underlying chronic medical condition that involves loss of bladder or bowel control;
- (3) Documentation must include the height and weight of the member, the type of incontinence (bowel/bladder/combined), and expected length of need;
- (4) Requests submitted for underwear/pull-on(s) the member must be ambulatory or in toilet training;
- (5) The member may qualify for incontinence supplies for a short period of time when the member has documented full-skin thickness injuries;
- (6) When requesting wipes as incontinence supplies, documentation must be submitted specific to the supply being requested. Disposable wipes are only allowed when diapers have been approved;
- (7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Quantity limits.** There is a quantity limit to the products allowed as well as product combinations. For a listing of quantity limits on specific products, refer to the OHCA website, under the Durable Medical Equipment page, "Incontinence Supplies". Requests for quantities or combinations outside of the limits published will require additional medical review for approval.

(e) **Non-covered items.** The following are non-covered items:

- (1) Incontinence supplies for members under the age of four (4) years;
- (2) Reusable underwear and/or reusable pull-ons;
- (3) Reusable briefs and/or reusable diapers;
- (4) Diaper service for reusable diapers;
- (5) Feminine hygiene products;
- (6) Disposable penile wraps; and
- (7) Shipping costs.

317:30-5-211.22. Pulse oximeter

(a) **Pulse oximeter.** Pulse oximeter is a device used for measuring blood oxygen levels in a non-invasive manner.

(b) **Medical necessity.** Pulse oximeters must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for pulse oximeters in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

- (1) A current oxygen order signed and dated by an OHCA-contracted physician, along with a certificate of medical necessity (CMN);
- (2) Pertinent information relating to the member's underlying diagnosis and condition which results in the need for the oximeter and supplies, including documentation of unstable airway events and documentation of current monitor readings if available; and
- (3) Documentation of an available trained caregiver in the home who is able to intervene and address changes in the member's oxygen saturation levels in a medically safe and appropriate manner.
- (4) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

- (1) Temporary probe covers are not reimbursed separately for rented oximeters as they are included in the price of the rental.
- (2) Pulse oximeters are not reimbursed in conjunction with apnea monitors.

317:30-5-211.23. Continuous passive motion device for the knee

(a) **Continuous passive motion (CPM).** CPM is a postoperative treatment method designed to aid recovery of joint range of motion after joint surgery. CPM provides for early post-operative motion and is considered a substitute for active physical therapy (PT).

(b) **Medical necessity.** CPM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for CPM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(1) A knee CPM device is covered for up to twenty-one (21) days and does not require a prior authorization (PA) for a patient in an early phase of rehabilitation.

(2) A knee CPM device required for more than twenty-one (21) days does require a PA of the additional days. These cases will be individually reviewed for medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Documentation must include:

(A) Type of surgery performed;

(B) Date of surgery;

(C) Date of application of CPM;

(D) Date of discharge from the hospital; and

(E) Written prescription issued by a licensed prescriber that is signed and dated no more than thirty (30) days prior to the first date of service and that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

(2) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Separate reimbursement will not be made for use of device while member is hospitalized or in a long-term care facility.

(2) Billing for dates of service when the patient is no longer actively using the CPM device is not appropriate and is not reimbursable.

317:30-5-211.24. Parenteral nutrition

(a) **Parenteral nutrition (PN).** PN is the provision of giving nutritional requirements intravenously.

(b) **Medical necessity.** PN must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for PN in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Hospital records that have objective medical evidence supporting the clinical diagnosis; if applicable;

(2) A certificate of medical necessity;

(3) A prescription; and

(4) Caloric Intake.

(5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Supply kits are all inclusive, unbundled supplies (e.g. gloves, tubing, etc.) are not reimbursable for PN.

(2) Pumps are rented as a capped rental.

317:30-5-211.25. Continuous glucose monitoring

(a) **Continuous glucose monitoring (CGM).** CGM means a minimally invasive system that measures glucose levels in subcutaneous or interstitial fluid. CGM provides blood glucose levels and can help members make more informed management decisions throughout the day.

(b) **Medical necessity.** CGM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for CGM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity. CGM devices must be approved by the U.S. Food and Drug Administration (FDA) as non-adjunctive and must be used for therapeutic purposes. Devices may only be used for members within the age range for which the devices have been FDA approved.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Requests for CGM must include all of the following documentation:

(1) Prescription by a physician, physician assistant, or an advanced practice registered nurse;

(2) Member diagnosis that correlates to the use of CGM;

(3) Documentation of the member testing to include the frequency each day;

(4) Documentation member is insulin-treated to include frequency of daily or is using insulin pump therapy;

(5) Documentation member's insulin treatment regimen requires frequent adjustment;

(6) The member and/or family member has participated in age appropriate diabetes education, training, and support prior to beginning CGM; and

(7) In-person or telehealth visit [within the last six (6) months] between the treating provider, member and/or family to evaluate their diabetes control.

(8) For full guidelines please refer to www.okhca.org/mau.

317:30-5-211.26. Bathroom equipment

(a) **Bathroom equipment.** Bathroom equipment is used for bathing and toileting and may be considered primarily medical in nature if used in the presence of an illness and/or injury and if it is necessary for activities of daily living that are considered to be essential to health and personal hygiene.

(b) **Medical necessity.** Bathroom equipment must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for

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bathroom equipment in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

- (1) Current written prescription for specific medical supply, equipment, and appliance item;
- (2) Letter of Medical Necessity;
- (3) Product Information;
- (4) Manufacturer's Suggested Retail Price (MSRP) for each item requested
- (5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.27. Positive airway pressure (PAP) devices

(a) **PAP devices.** PAP devices are both a single level continuous positive airway pressure device (CPAP), and/or a bi-level respiratory assist device with or without back-up rate when it is used in the treatment of obstructive sleep apnea.

(b) **Medical Necessity.** PAP devices must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for PAP devices in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

- (1) A face-to-face clinical evaluation by the treating qualified medical professional within six (6) months prior to receiving device;
- (2) Qualifying polysomnogram, performed in a sleep diagnostic testing facility, that is dated within one (1) year of the prior authorization request submission;
- (3) The patient and/or his or her caretaker have received instruction from the supplier of the device in the proper use and care of the equipment; and
- (4) Medical records supporting the need for a PAP device.
- (5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.28. Sleep studies

(a) **Sleep studies.** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep

for six (6) or more hours. The study is used to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). A sleep study requires physician review, interpretation, and report.

(b) **Medical necessity.** Sleep studies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for sleep studies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation requirements include:

- (1) Legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient;
 - (2) All pages in the prior authorization request must be clear and legible;
 - (3) Face-to-face evaluation by the ordering practitioner, the supervising physician, or the interpreting physician; and
 - (4) Medical records to support the medical indication for the sleep study including results of sleep scale.
 - (5) For full guidelines, please refer to www.okhca.org/mau.
- (d) **Reimbursement.**
- (1) Only sleep studies performed in a sleep diagnostic testing facility may be reimbursable.
 - (2) A split study beginning on a given date with the titration beginning after midnight on the subsequent date is one (1) study and may not be billed as two (2) consecutive studies.

317:30-5-216. Prior authorization requests [REVOKED]

(a) **Prior authorization requirements.** Requirements vary for different types of services. Providers should refer to the service specific sections of policy or the OHCA website for services requiring PA.

- (1) **Required forms.** All required forms are available on the OHCA web site at www.okhea.org.
- (2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and

the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.

(b) ~~Submitting prior authorization requests.~~ Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web-site.

(c) ~~Prior authorization review.~~ Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(d) ~~Prior authorization decisions.~~ After the PA request is processed, a notice will be issued regarding the outcome of the review. If the request is approved the notice will include an authorization number, the appropriate date span and procedure codes approved.

(e) ~~Prior authorization does not guarantee reimbursement.~~ Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(f) ~~Prior authorization of manually priced items.~~ Manually priced items must be prior authorized. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of two. OHCA may establish a fair market price through claims review and analysis.

317:30-5-218. Reimbursement

(a) Medical equipment and supplies, equipment and appliances.

(1) ~~Reimbursement for durable medical equipment and supplies~~ medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the ~~OHCA~~ Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established. ~~The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

(2) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency, budget considerations, federal regulations, and quality of care as determined by the OHCA.

(3) Payment for medical supplies, equipment, and appliances will be calculated using the rate methodologies found in the Oklahoma Medicaid state plan.

(4) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over the counter.

(5) OHCA does not pay medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

(6) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to Medicare Part B, Average Sales Price (ASP) + six percent (6%). When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) Manually-priced medical equipment and supplies. There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(1) Invoice pricing. Reimbursement is at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(2) Fair market pricing. OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the Fair Market Value List (Selected medical supplies, equipment, and appliance items priced at Fair Market Price).

(bc) Oxygen equipment and supplies.

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g. regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

(4) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

PART 61. HOME HEALTH AGENCIES

Emergency Adoptions

317:30-5-545. Eligible providers

All eligible home health service providers must be Medicare certified, accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), or have deemed status with Medicare, and have a current contract with the Oklahoma Health Care Authority (OHCA). Home Health Agencies health agencies billing for durable medical equipment (DME) medical supplies, equipment, and appliances must have a supplier contract and bill equipment on claim form CMS-1500. Additionally, home health services providers that did not participate in Medicaid prior to January 1, 1998, must meet the "Capitalization Requirements" set forth in 42 CFR 489.2842 Code of Federal Regulations (C.F.R.) § 489.28. Home health services providers that do not meet these requirements will not be permitted to participate in the Medicaid program.

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this section when a face-to-face encounter has occurred in accordance with provisions of 42 CFR 440.70.42 Code of Federal Regulations (C.F.R.) § 440.70. Payment is made for home health services provided in the member's residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, or intermediate care facility for individuals with intellectual disabilities. For individuals eligible for Part B of Medicare, payment is made utilizing the Medicaid allowable for comparable services.

(1) **Adults.** Payment is made for home health services provided in the member's residence to all categorically needy individuals. Coverage for adults is as follows:

(A) Covered items.

- (i) Part time or intermittent nursing services;
- (ii) Home health aide services;
- (iii) Standard medical supplies;
- (iv) Durable medical equipment (DME) and appliances; and
- (v) Items classified as prosthetic devices.

(B) **Non-covered items.** The following are not covered:

- (i) Sales tax;
- (ii) Enteral therapy and nutritional supplies;
- (iii) Electro spinal orthosis system (ESO); and
- (iv) Physical therapy, occupational therapy, speech pathology, or audiological services.

(2) **Children.** Home Health Services are covered for persons under age 21.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. Reimbursement for any

combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary. Thirty-six (36) visits per calendar year of nursing and/or home health aide services for any member do not require prior authorization; however, any visit surpassing thirty-six (36) would require prior authorization and medical review.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the ~~OHCA~~ Oklahoma Health Care Authority (OHCA) fee schedule or the provider's usual and customary charge. ~~The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code.~~ When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate.~~ The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

317:30-5-548. Procedure codes

~~Procedure codes for home health services are assigned HCPCS codes for supplies and durable medical equipment. All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.~~

317:30-5-549. Prosthetic devices [REVOKED]

Payment may be made to home health agencies for prosthetic devices. Refer to the Medical Suppliers Provider Rules for further information.

[OAR Docket #20-650; filed 7-21-20]

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

[OAR Docket #20-651]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 18. Programs of All-Inclusive Care for the Elderly (PACE)

317:35-18-6 [AMENDED]

(Reference APA WF # 20-06B)

AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 6407 of the Affordable Care Act; Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015; CMS-2348-F Final Rule; Public Law 114-10; 42 Code of Federal Regulations (C.F.R.) § 440.70; and 42 C.F.R. § 440.120

ADOPTION:

June 30, 2020

EFFECTIVE:

Immediately upon Governor's approval or August 1, 2020, whichever is later.

APPROVED BY GOVERNOR:

July 13, 2020

EXPIRATION:

Effective through September 14, 2021, 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 requests emergency approval of rule revisions to medical supplier, home health agency, long-term care facility, hospitals, and general provider policies in order to avoid violation of federal law or regulation. Revisions will bring the agency into compliance with the Home Health final rule which was effective July 1, 2016, and which changes medical supplies, equipment, and appliances (formerly called durable medical equipment) from an optional benefit to a mandatory benefit as well as expands the services required under this mandatory benefit.

GIST/ANALYSIS:

These emergency revisions are necessary in order to remove certain limits on coverage of DME and supplies, to change the place of service for which DME and supplies may be provided from a member's place of residence to any setting in which normal life activities take place except for inpatient settings, to require and define a face-to-face encounter between a member and a practitioner before the provision of DME and supplies, to require nursing facilities and intermediate care facilities for individuals with intellectual disabilities to provide certain DME and supplies without separate reimbursement from their monthly vendor payment, and to change the name of durable medical equipment to medical supplies, equipment, and appliances.

CONTACT PERSON:

Sandra Puebla, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F), AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR AUGUST 1, 2020, WHICHEVER IS LATER:

**SUBCHAPTER 18. PROGRAMS OF
ALL-INCLUSIVE CARE FOR THE ELDERLY
(PACE)**

317:35-18-6. PACE program benefits

(a) The PACE program offers a comprehensive benefit plan. A provider agency must provide a participant all the services listed in ~~42 CFR 460.92~~ Section (§) 460.92 of Title 42 of the Code of Federal Regulations (C.F.R.) that are approved by the ~~IDT interdisciplinary team (IDT)~~. The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

- (1) All SoonerCare-covered services, as specified in the State's approved ~~SoonerCare plan~~ Medicaid State Plan;
- (2) ~~Interdisciplinary assessment~~ IDT and treatment planning;
- (3) Primary care, including physician and nursing services;
- (4) Social work services;
- (5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services;
- (6) Personal care and supportive services;
- (7) Nutritional counseling;
- (8) Recreational therapy;
- (9) Transportation;
- (10) Meals;
- (11) Medical specialty services including, but not limited to the following:
 - (A) Anesthesiology;
 - (B) Audiology;
 - (C) Cardiology;
 - (D) Dentistry;
 - (E) Dermatology;
 - (F) Gastroenterology;
 - (G) Gynecology;
 - (H) Internal medicine;
 - (I) Nephrology;
 - (J) Neurosurgery;
 - (K) Oncology;
 - (L) Ophthalmology;
 - (M) Oral surgery;
 - (N) Orthopedic surgery;
 - (O) Otorhinolaryngology;
 - (P) Plastic surgery;
 - (Q) Pharmacy consulting services;
 - (R) Podiatry;
 - (S) Psychiatry;
 - (T) Pulmonary disease;
 - (U) Radiology;
 - (V) Rheumatology;
 - (W) General surgery;
 - (X) Thoracic and vascular surgery; and
 - (Y) Urology.
- (12) Laboratory tests, x-rays, and other diagnostic procedures;
- (13) Drugs and biologicals;

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- (14) Prosthetics, orthotics, ~~durable medical equipment, medical supplies, equipment, and appliances,~~ corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items;
- (15) Acute inpatient care, including the following:
- (A) Ambulance;
 - (B) Emergency room care and treatment room services;
 - (C) Semi-private room and board;
 - (D) General medical and nursing services;
 - (E) Medical surgical/intensive care/coronary care unit;
 - (F) Laboratory tests, x-rays, and other diagnostic procedures;
 - (G) Drugs and biologicals;
 - (H) Blood and blood derivatives;
 - (I) Surgical care, including the use of anesthesia;
 - (J) Use of oxygen;
 - (K) Physical, occupational, respiratory therapies, and speech-language pathology services; and
 - (L) Social services.
- (16) Nursing facility (NF) care, including:
- (A) Semi-private room and board;
 - (B) Physician and skilled nursing services;
 - (C) Custodial care;
 - (D) Personal care and assistance;
 - (E) Drugs and biologicals;
 - (F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
 - (G) Social services; and
 - (H) Medical supplies, equipment, and appliances.
- (17) Other services determined necessary by the ~~interdisciplinary team~~ IDT to improve and maintain the participant's overall health status.
- (b) The following services are excluded from coverage under PACE:
- (1) Any service that is not authorized by the ~~interdisciplinary team~~ IDT, even if it is a required service, unless it is an emergency service.
 - (2) In an inpatient facility, private room and private duty nursing (PDN) services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the ~~interdisciplinary team~~ IDT as part of the participant's plan of care).
 - (3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
 - (4) Experimental medical, surgical, or other health procedures.
 - (5) Services furnished outside of the United States, except as follows:
 - (A) ~~in~~ In accordance with 42 ~~CFR~~ C.F.R. § 424.122 through 42 ~~CFR~~ C.F.R. § 424.124, and
 - (B) ~~as~~ As permitted under the State's approved Medicaid ~~plan~~ State Plan.

- (c) In the event that a PACE participant is in need of permanent placement in a ~~nursing facility~~ NF, a Medicaid premium will be imposed. OKDHS will calculate a vendor co-payment for those participants using the same methodology as is used for any Oklahoma Medicaid member who is accessing ~~nursing facility~~ NF level of care. However, for a PACE participant, the ~~participants~~ participant's responsibility will be to make payment directly to the PACE provider; the amount to be specified by the OKDHS worker. There are no other share of costs requirements for PACE.
- (d) All PACE ~~Program Benefits~~ program benefits are offered through the duration of the PACE participant's enrollment in the PACE program. PACE enrollment does not cease once a participant's condition necessitates or the PACE IDT recommends that ~~they~~ he or she be institutionalized.

[OAR Docket #20-651; filed 7-21-20]

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

[OAR Docket #20-652]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Member Services
Part 9. Service Provisions
317:40-5-104 [AMENDED]
(Reference APA WF # 20-06C)

AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 6407 of the Affordable Care Act; Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015; CMS-2348-F Final Rule; Public Law 114-10; 42 Code of Federal Regulations (C.F.R.) § 440.70; and 42 C.F.R. § 440.120

ADOPTION:

June 30, 2020

EFFECTIVE:

Immediately upon Governor's approval or August 1, 2020, whichever is later.

APPROVED BY GOVERNOR:

July 13, 2020

EXPIRATION:

Effective through September 14, 2021, 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 requests emergency approval of rule revisions to medical supplier, home health agency, long-term care facility, hospitals, and general provider policies in order to avoid violation of federal law or regulation. Revisions will bring the agency into compliance with the Home Health final rule which was effective July 1, 2016, and which changes medical supplies, equipment, and appliances (formerly called durable medical equipment) from an optional benefit to a mandatory benefit as well as expands the services required under this mandatory benefit.

GIST/ANALYSIS:

These emergency revisions are necessary in order to remove certain limits on coverage of DME and supplies, to change the place of service for which DME and supplies may be provided from a member's place of residence to any setting in which normal life activities take place except for

inpatient settings, to require and define a face-to-face encounter between a member and a practitioner before the provision of DME and supplies, to require nursing facilities and intermediate care facilities for individuals with intellectual disabilities to provide certain DME and supplies without separate reimbursement from their monthly vendor payment, and to change the name of durable medical equipment to medical supplies, equipment, and appliances.

CONTACT PERSON:

Sandra Puebla, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F), AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR AUGUST 1, 2020, WHICHEVER IS LATER:

SUBCHAPTER 5. MEMBER SERVICES

PART 9. SERVICE PROVISIONS

317:40-5-104. Specialized medical supplies

(a) **Applicability.** The rules in this ~~section~~Section apply to ~~specialized medical supplies~~medical supplies, equipment, and appliances provided through ~~Home and Community Based Services (HCBS) Waivers~~home and community-based waiver services operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD)~~(DDS).

(b) **General information.** ~~Specialized medical supplies~~Medical supplies, equipment, and appliances include supplies specified in the plan of care that enable the member to increase his or her ability to perform activities of daily living. ~~Specialized medical supplies~~Medical supplies, equipment, and appliances include the purchase of ancillary supplies not available through SoonerCare.

(1) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances must be included in the member's plan and arrangements for this service must be made through the member's case manager. Items reimbursed with ~~Home and Community Based Services~~home and community-based waiver services (HCBS) funds are in addition to any supplies furnished by SoonerCare.

(2) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances meet the criteria for service necessity given in ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-3-33.1.

(3) All items meet applicable standards of manufacture, design, and installation.

(4) ~~Specialized medical supplies~~Medical supplies, equipment, and appliance providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement with the Oklahoma Health Care Authority, and be registered to do business in Oklahoma or the state in which they are domiciled. Providers must enter into the agreement giving assurance of ability to provide products and services and agree to the

audit and inspection of all records concerning goods and services provided.

(5) Items that can be purchased as ~~specialized~~ medical supplies, equipment, and appliances include:

- (A) ~~incontinence~~Incontinence supplies, as described in subsection (b) of this Section;
- (B) ~~nutritional~~Nutritional supplements;
- (C) ~~supplies~~Supplies for respirator or ventilator care;
- (D) ~~decubitus~~Decubitus care supplies;
- (E) ~~supplies~~Supplies for catheterization; and
- (F) ~~supplies~~Supplies needed for health conditions.

(6) Items that cannot be purchased as ~~specialized~~ medical supplies, equipment, and appliances include:

- (A) ~~over the counter~~Over-the-counter medication(s);
- (B) ~~personal~~Personal hygiene items;
- (C) ~~medicine~~Medicine cups;
- (D) ~~items~~Items that are not medically necessary; and
- (E) ~~prescription~~Prescription medication(s).

(7) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances must be:

- (A) ~~necessary~~Necessary to address a medical condition;
- (B) ~~of~~Of direct medical or remedial benefit to the member;
- (C) ~~medical~~Medical in nature; and
- (D) ~~consistent~~Consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

(c) **Limited coverage.** Items available in limited quantities through ~~specialized~~ medical supplies, equipment, and appliances include:

- (1) ~~incontinence~~Incontinence wipes, ~~300~~three-hundred (300) wipes per month;
- (2) ~~non-sterile~~Non-sterile gloves, as approved by the Team;
- (3) ~~disposable~~Disposable underpads, ~~60~~sixty (60) pads per month; and
- (4) ~~incontinence~~Incontinence briefs, ~~180~~one-hundred and eighty (180) briefs per month.

(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the ~~Team~~team.

(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the ~~DDSD~~DDS nurse when the member has a medical condition that precludes implementation of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.

(d) **Exceptions.** Exceptions to the requirements of this Section are explained in this subsection.

(1) When a member's ~~Team~~team determines that the member needs medical supplies that:

- (A) ~~are~~Are not available through SoonerCare and for which no ~~Health Care Procedure Code~~healthcare

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common procedure code exists, the case manager e-mails pertinent information regarding the member's medical supply need to the programs manager responsible for ~~Specialized Medical Supplies~~medical supplies, equipment, and appliances. The e-mail includes all pertinent information that supports the need for the supply, including but not limited to, quantity and purpose; or

(B) ~~exceed~~Exceed the limits stated in subsection(c) of this Section, the case manager documents the need in the ~~Individual Plan~~individual plan for review and approval per OAC 340:100-33.

(2) Approval or denial of exception requests is made on a ~~case by case~~case-by-case basis and does not override the general applicability of this Section.

(3) Approval of a ~~specialized medical supplies~~medical supplies, equipment, and appliances exception does not exceed one (1) plan of care year.

[OAR Docket #20-652; filed 7-21-20]

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

[OAR Docket #20-653]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. Medically Fragile Waiver Services

317:50-1-14 [AMENDED]

(Reference APA WF # 20-06D)

AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 6407 of the Affordable Care Act; Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015; CMS-2348-F Final Rule; Public Law 114-10; 42 Code of Federal Regulations (C.F.R.) § 440.70; and 42 C.F.R. § 440.120

ADOPTION:

June 30, 2020

EFFECTIVE:

Immediately upon Governor's approval or August 1, 2020, whichever is later.

APPROVED BY GOVERNOR:

July 13, 2020

EXPIRATION:

Effective through September 14, 2021, 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 requests emergency approval of rule revisions to medical supplier, home health agency, long-term care facility, hospitals, and general provider policies in order to avoid violation of federal law or regulation. Revisions will bring the agency into compliance with the Home Health final rule which was effective July 1, 2016, and which changes medical supplies, equipment, and appliances (formerly called durable medical equipment) from

an optional benefit to a mandatory benefit as well as expands the services required under this mandatory benefit.

GIST/ANALYSIS:

These emergency revisions are necessary in order to remove certain limits on coverage of DME and supplies, to change the place of service for which DME and supplies may be provided from a member's place of residence to any setting in which normal life activities take place except for inpatient settings, to require and define a face-to-face encounter between a member and a practitioner before the provision of DME and supplies, to require nursing facilities and intermediate care facilities for individuals with intellectual disabilities to provide certain DME and supplies without separate reimbursement from their monthly vendor payment, and to change the name of durable medical equipment to medical supplies, equipment, and appliances.

CONTACT PERSON:

Sandra Puebla, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F), AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR AUGUST 1, 2020, WHICHEVER IS LATER:

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

Services included in the Medically Fragile ~~Waiver~~waiver program are as follows:

(1) Case Management.

(A) Case ~~Management~~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 service plan, 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 service plan reviews. If a member requires hospital or skilled nursing facility (NF) 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~~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~~Oklahoma Administrative Code (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. Payment is not allowed for written reports or record documentation.

(C) Case ~~Management~~management services are prior authorized and billed per ~~fifteen minute~~fifteen (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 twenty-five (25) persons per square mile.

(ii) ~~Very rural/difficult service area rate:~~ Case management services are billed using a very ~~rural/difficult~~rural/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An exception would be services to members that reside in ~~OHCA identified~~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 twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(D) Case managers providing case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile ~~Waiver~~waiver staff.

(E) Providers of Home and ~~Community-Based Services~~Community-Based waiver 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 transitional case management.**

(A) Institutional Transition case management services are required by the member's service plan, 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) Institutional 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) Institutional 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's 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 (7) hours are provided in a nursing facility- (NF). Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) ~~In Home Respite~~In-home respite services are billed per fifteen (15) minute unit service. Within any ~~one day~~one (1) day period, a minimum of eight (8) units must be provided with a maximum of ~~28~~twenty-eight (28) units provided. The service is provided in the member's home.

(C) ~~Facility Based Extended Respite~~Facility-based extended respite is filed for a per diem rate, if provided in ~~Nursing Facility~~a NF. Extended ~~Respite~~respite must be at least eight (8) hours in duration.

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(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) **Environmental Modifications, modifications.**

(A) Environmental ~~Modifications~~ modifications are physical adaptations to the home, required by the member's service plan, 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~~ waiver member are excluded.

(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines, Title 28 of the Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

(5) ~~Specialized Medical Equipment and Supplies~~ **Medical Supplies, Equipment, and Appliances.**

(A) ~~Specialized medical equipment and supplies are devices, controls, or appliances~~ Medical supplies, equipment, and appliances are specified in the service plan, 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 and supplies not available under the ~~Medicaid state plan~~ 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~~ Medical supplies, equipment, and appliances are billed using the appropriate ~~HCP~~ healthcare common procedure code. ~~(HCPC)~~. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for ~~Waiver~~ waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled ~~nursing facility~~ (NF) or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for ~~medical supplies~~ medical supplies, equipment, and appliances is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented ~~Manufacturer's Suggested Retail Price~~ manufacturer's suggested retail price

(MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two. (2). OHCA may establish a fair market price through claims review and analysis.

(6) ~~Advanced Supportive/Restorative Assistance~~ **supportive/restorative assistance.**

(A) ~~Advanced Supportive/Restorative Assistance~~ 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~~ supportive/restorative assistance service is billed per fifteen (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 service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan 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 service plan. 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~~The member's general health, functional ability and needs and/or
 - (II) ~~the~~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~~Preparing a one (1) 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~~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~~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~~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 fifteen (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 (8) 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 (1) 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 (1/3) 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 service plan. 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

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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 fifteen (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 fifteen (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 fifteen (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~~ ~~therapy~~ services are billed per fifteen (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 (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) 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 (30) 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 sixty (60) days increments with physician certification that the member has a terminal illness and has six (6) 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 (5) days during any thirty (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) Personal Care.

(A) 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) Personal Care services are prior authorized and billed per fifteen (15) minute unit of service with

units of service limited to the number of units on the approved service plan.

(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 ~~aaa~~ Medically Fragile program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

- (i) ~~aA~~ 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~~Lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) ~~demonstrates~~Demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) ~~has~~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~~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~~The service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

(16) Prescription drugs. Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 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 service plan prior to initiation of any Self-Directed activities.

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(B) The OHCA uses the following criteria to determine a member's eligibility to participate in the Self-Directed option:

(i) ~~have~~Have an existing need for Self-Directed services to prevent institutionalization;

(ii) ~~member's~~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~~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~~The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup; or

(III) ~~the~~The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past ~~12~~twelve (12) months and does not have an authorized representative with capacity to assist with Self-Direction responsibilities; or

(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 Care Assistant~~PCA. 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 able to participate in the Self-Directed services option:

(i) ~~the~~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~~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 PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) ~~the~~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~~The member abuses or exploits their employee; or

(v) ~~the~~The member falsifies time-sheets or other work records; or

(vi) ~~the~~The member, even with case manager and financial management services assistance, is unable to operate successfully within their Individual Budget Allocation (IBA); or

(vii) ~~inferior~~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 legal 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~~respite or PCA and/or the ASR provider 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~~Recruits, hires and, as necessary, discharges the PCA and ASR;

(ii) ~~provides~~Provides instruction and training to the PCA or ASR 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 ASR provider task for the first time, the ASR 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 ASR provider personnel file;
- (iii) ~~determines~~Determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;
- (iv) ~~supervises~~Supervises and documents employee work time; and;
- (v) ~~provides~~Provides tools and materials for work to be accomplished.

(G) FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. FMS 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~~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 PCA or ASR provider;
- (ii) ~~other~~Other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;
- (iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;
- (iv) ~~providing~~Providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with IBA 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 PCA or ASR provider; and

(H) The service of ~~Respite~~respite or PCA is billed per fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR 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 IBA expenditure accounts determination process for each member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

- (i) The 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 PCA and ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR 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 IBA 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 PCA or ASR 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 service plan.

(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile wavier staff. Documentation must be available upon request.

(19) Transitional case management.

(A) Transitional case management are one-time billable expenses for members who transition from within the community to the Medically Fragile wavier.

(B) Transitional case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) Transitional case management assist 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

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the funding source for the services which access is gained.

(D) Transitional case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

[OAR Docket #20-653; filed 7-21-20]

TITLE 405. OKLAHOMA DEPARTMENT OF LIBRARIES CHAPTER 25. STATE AID GRANTS TO PUBLIC LIBRARIES

[OAR Docket #20-586]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

405:25-1-3 [AMENDED]

AUTHORITY:

Oklahoma Department of Libraries Board; 65 O.S. § 2-106(m)

ADOPTION:

May 28, 2020

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

July 1, 2020

EXPIRATION:

Effective through September 14, 2021, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

One of the ways the Oklahoma Department of Libraries supports quality library services is through the disbursement of State Aid Grants to Public Libraries. Libraries become eligible to receive disbursements by meeting the requirements outlined in the Oklahoma Administrative Code. All of the state's public libraries have been impacted by the catastrophic health emergency and will be ineligible for state aid in FY2021 which is based on FY2020 operations. According to OAC 405:25-1-3(2)(B) [User service requirements], "Libraries shall be open to the public the minimum number of hours stipulated in the following schedule. These hours shall be maintained year round." In response to the Governor's emergency declarations and local shelter in place orders implemented to flatten the curve, all of the state's public libraries reduced their hours and will no longer meet this minimum requirement for the year.

An additional requirement that will not be met as a result of the response to COVID-19 relates to finance requirements. OAC 405:25-1-3(3)(D) [Administration of finance requirements] states, "Local government must continue to expend an amount for library service, i.e., operation expenditures, not less than that of the preceding fiscal year." Municipalities have reported significant budget cuts due to shelter in place orders resulting in lost sales tax revenue. The purpose of state aid is to support public libraries. Without the ability to modify the rules, Oklahoma's public libraries will not be eligible to receive disbursements for FY 2021.

GIST/ANALYSIS:

The proposed rule adds language that allows the Oklahoma Department of Libraries Board (ODL) and the ODL Director to determine when emergency or extraordinary circumstances exist that render a public library or libraries ineligible for state aid funding and the authority to modify the requirements that must be met in order to be eligible for state aid funding. Emergencies are declared by the President of the United States or the Governor of the State of Oklahoma. Examples of extraordinary circumstances are a significant fire or flooding in library facilities. Under these conditions that are outside the control

of the local government, the ODL Director will present a recommendation for specific requirement(s) that can be suspended or modified to allow the library to receive state aid funding that otherwise it would not be eligible to receive as a result of the stated condition. The board may accept the recommendation of the ODL Director or deny the recommendation. Current rules provide no allowance for emergency or extraordinary circumstances.

CONTACT PERSON:

Jan Davis, Administrative Archivist, Oklahoma Department of Libraries, 200 NE 18th Street, Oklahoma City, OK 73105, 405-522-3191, jan.davis@libraries.ok.gov

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):

405:25-1-3. Eligibility for State aid grants to public libraries

Eligibility for state aid grants to public libraries is governed by the ~~following requirements listed below:~~ Eligibility may be impacted by emergency declarations by the President of the United States or the Governor of Oklahoma, public health, public safety, or other extraordinary circumstances as determined by the Director of the Oklahoma Department of Libraries and the ODL Board. Under those conditions, the Director will present recommendations to the ODL Board to modify application of specific User Service or Administration and Finance requirements. The ODL Board has the authority to accept or deny the recommendations.

(1) Basic requirements.

- (A) Libraries must meet the definition of a public library as defined in 65 O.S. § 1-104.
- (B) Libraries must be legally established and operating according to Oklahoma Statutes, Title 65, Article 4, § 101 and Title 11, Article 31; and Article 10, § 10A of the Oklahoma Constitution.

(2) User service requirements.

- (A) Libraries must provide free library service.
- (B) Libraries shall be open to the public the minimum number of hours stipulated in the following schedule. These hours shall be maintained year round. Single county systems organized under 65 O.S., §§ 151 and 552 which have branch libraries may aggregate their hours, if, discounting overlap, the citizens are served according to the following schedule:
 - (i) cities and towns under 2,000 population will be open 15 hours a week. The schedule will include at least two hours after 5 p.m. each week;
 - (ii) cities and towns of at least 2,000 but less than 5,000 people, will be open 30 hours a week. The schedule will include at least two hours after 5 p.m. each week and weekend hours are recommended;
 - (iii) cities with at least 5,000 but less than 10,000 people, will be open 35 hours a week. The schedule will include at least four hours after 5 p.m. each week and three weekend hours;

- (iv) cities with at least 10,000, but less than 25,000, will be open 50 hours a week. The schedule will include at least eight hours after 5 p.m. each week and four weekend hours; and
- (v) cities with 25,000 or more will be open 60 hours a week. The schedule will include a minimum of five weekend hours.
- (C) Libraries must have a telephone located in the library with a listed number.
- (D) All libraries and branches must provide internet access to the public. The library shall have a written internet use policy.
- (E) All libraries shall at a minimum offer programming for youth under 18 years of age.
- (F) A public library shall have a collection of materials (e.g., books, periodicals, audio-visual materials, etc.) that is circulated to the community.
 - (i) Libraries shall provide bibliographic access to its collection for customers.
 - (ii) The library shall offer interlibrary loan to customers and participate in interlibrary loan networks or consortia to borrow materials not held in the library upon request for customers. Libraries shall promote the service to customers through promotional materials and/or signs in the library and on its website to make customers aware of the service.
 - (iii) The library shall do an age and condition study on its collection every four years as determined by the Oklahoma Department of Libraries and report the findings to its library board and the Oklahoma Department of Libraries.
- (3) **Administration and finance requirements.**
 - (A) Legally established libraries that are not part of a library system must complete and submit the Oklahoma Department of Libraries' online annual report for the preceding fiscal year by August 15th and library systems must submit such reports by October 1st.
 - (B) Libraries must have a board of trustees appointed by the city and or county government officials which holds regularly scheduled meetings at least quarterly and all libraries must file annually a list of trustees, terms of office and meeting times with the Oklahoma Department of Libraries. The board shall approve the policies by which the library operates. The board shall review all required policies within a four year cycle as determined by the Oklahoma Department of Libraries and shall report all current policies to the Oklahoma Department of Libraries. Required policies are:
 - (i) Circulation policy which shall include interlibrary loan;
 - (ii) Library materials selection policy; and
 - (iii) Internet use policy.
 - (C) Libraries must receive operating income from local government sources, i.e. town, city or county.

A public library is primarily supported by either municipal funds or a direct library levy on a permanent basis.

(D) Local government must continue to expend an amount for library service, i.e., operating expenditures, not less than that of the preceding fiscal year, as reported on the Annual Report for Public Libraries. Public library systems organized under 65 O.S. Sections 151-161 and Sections 551-561, Sections 4-101-107.1 and Sections 4-201-206 may not reduce their millage levy. Exemption waivers to drop in operating income based on special circumstances shall be considered.

(i) If a city or county has less total income for the most recent fiscal year as compared to the immediate fiscal year, exemption to the requirement in (D) of this paragraph may be made. The Oklahoma Department of Libraries will then supply forms for city or county officials to certify that the library's budget sustained no greater reduction than the total percentage reduction of income of the city or county budget.

(ii) The requirement in (D) of this paragraph may be waived in those years when the budget is decreased according to (i) of this subparagraph.

(E) Libraries must have paid permanent employees who are employees of the town, city, county or system. Town, city, county or system must pay said employees at least the federally required minimum wage and meet the requirements of the Fair Labor Standards Act.

(F) All library directors and all personnel who work more than twenty (20) hours a week must attend at least one continuing education program each year. Staff in library systems or public libraries serving over 25,000 may meet this requirement with in-house training. Personnel are exempt if they have been employed at the library less than one (1) year.

(G) Multi-county library systems must abide by the Oklahoma Department of Libraries' rules concerning systems as set forth in Chapter 10 of this title.

(H) Libraries must file with the Oklahoma Department of Libraries, Office of Library Development, a report of expenditures made with state aid grant funds each preceding fiscal year by August 15th and library systems must submit such reports by October 1st.

(I) Libraries must have a written statement of purpose.

(J) Libraries shall provide annual library visits each year on the annual report to the Oklahoma Department of Libraries.

(K) Libraries must provide bibliographic access to their collections.

(L) Libraries serving a population of 10,000 or more must have submitted to the Oklahoma Department of Libraries a long range plan written or updated within the last 3 years. This document must address

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future directions of the library for services and resources, and must be approved by the local library board.

(M) Libraries that are a department of municipal government in cities serving a population of 25,000 or more must employ a director with a Master's Degree in Library and Information Science from a library school accredited by the American Library Association or an alternate degree as follows. A comparable master's degree in business, education, school library media, or public administration, with a minimum of five years of prior supervisory library experience shall also be acceptable. For those with an alternate degree but without prior experience working in a library, the director shall complete the Institute in Public Librarianship Certification Program within two years of employment as director.

(N) Libraries will evaluate, deselect and maintain their collections ensuring that their collections include up-to-date and useful materials and report the figures to its library board and to the Oklahoma Department of Libraries.

(O) Libraries shall submit performance measures to the Oklahoma Department of Libraries on a schedule as determined by the Oklahoma Department of Libraries.

[OAR Docket #20-586; filed 7-10-20]

TITLE 540. PHYSICIAN MANPOWER TRAINING COMMISSION CHAPTER 30. OKLAHOMA NURSING STUDENT ASSISTANCE PROGRAM

[OAR Docket #20-628]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. General Provisions

540:30-1-2 [AMENDED]

Subchapter 3. Role of Nursing Scholarship Advisory Committee

540:30-3-1 [AMENDED]

Subchapter 5. Categories of Scholarships

540:30-5-1 [AMENDED]

540:30-5-2 [AMENDED]

Subchapter 7. Eligibility

540:30-7-1 [AMENDED]

540:30-7-2 [AMENDED]

540:30-7-4 [AMENDED]

Subchapter 9. Application Process

540:30-9-1 [AMENDED]

Subchapter 11. Loan Provisions

540:30-11-1 [AMENDED]

540:30-11-2 [AMENDED]

540:30-11-3 [AMENDED]

540:30-11-5 [AMENDED]

540:30-11-6 [AMENDED]

Subchapter 15. General Administrative Policies

540:30-15-1 [AMENDED]

Subchapter 17. Service Obligation

540:30-17-2 [AMENDED]

AUTHORITY:

Physician Manpower Training Commission; 70 O.S., § 697.17

COMMENT PERIOD:

April 15, 2020 through May 15, 2020

PUBLIC HEARING:

May 18, 2020

ADOPTION:

May 18, 2020

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

July 10, 2020

EXPIRATION:

Effective through September 1, 2021 unless superseded by another rule or disapproved by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The Board of Commissioners of the Physician Manpower Training Commission, has adopted the proposed change to Oklahoma Nursing Student Assistance Program. This rule change also changes the yearly payout for nurses over the four year maximum participation period.

The proposed changes would expand to higher nursing degree programs, expand eligible facilities to fulfill obligations and increase the amount of awards for the Oklahoma Nursing Student Assistance Program to be consistent with other PMTC programs and meet the current nursing needs across all of rural Oklahoma. This proposed change is an effort to place rural Oklahoma in a more competitive recruiting position against neighboring states. This change results in the same overall budgeted amount for the Oklahoma Nursing Student Assistance Program.

These changes also provide revision to change restrictive phrases in the rules according to Executive Order 2020-03.

GIST/ANALYSIS:

The Board of Commissioners of the Physician Manpower Training Commission, has adopted the proposed changes for the Oklahoma Nursing Student Assistance Program.

The proposed changes would expand to higher nursing degree programs, expand eligible facilities to fulfill obligations and increase the amount of awards for the Oklahoma Nursing Student Assistance Program to be consistent with other PMTC programs and meet the current nursing needs across all of rural Oklahoma. This change has no fiscal impact to the agency.

The proposed changes are in an effort to align PMTC programs providing consistent practices in providing greater assistance in recruiting nurses across rural Oklahoma.

CONTACT PERSON:

Michelle Cecil, Nursing Programs Director, (405) 604-0020, Michelle.Cecil@pmtc.ok.gov, Janie Thompson, Executive Director, (405) 604-0020, Janie.Thompson@pmtc.ok.gov or for legal questions: Joe Ashbaker, Assistant Attorney General, (405) 522-2974, Joe.Ashbaker@oag.ok.gov.

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

SUBCHAPTER 1. GENERAL PROVISIONS

540:30-1-2. Scope of program

Scholarship loans are available for study prerequisite to licensure as a Practical Nurse, Registered Nurse, or the awarding of a Master's Degree in Nursing or higher and for the upward mobility of LPN's and AD and Diploma RN's to Baccalaureate in Nursing. The Nurse Education Scholarship Program is a loan program, with repayment to be made through work service to the sponsor. Loan paybacks would be based

on one year of service for each academic year in the program, with a minimum of one year service obligation. For students enrolled in the BSN program, funding is available for only the last two years of study. For students enrolled in the MSN-NP, MSN-EDU, DNP or Ph.D. programs, funding is available for two to five years.

SUBCHAPTER 3. ROLE OF NURSING SCHOLARSHIP ADVISORY COMMITTEE

540:30-3-1. Role of Nursing Scholarship Advisory Committee

- (a) A Nursing Scholarship Advisory Committee (NSAC) ~~shall~~will assist and advise the Physician Manpower Training Commission relative to the Nursing Student Assistance Program.
- (b) Recipients will be selected by the Physician Manpower Training Commission assisted by recommendations of a twelve member Nursing Scholarship Advisory Committee. The Nursing Scholarship Advisory Committee will be appointed by the Physician Manpower Training Commission and will consist of:
 - (1) a Rural Hospital Nursing Service Administrator, representing the Oklahoma Organization of Nurse Executives,
 - (2) an Urban Hospital Nursing Service Administrator, representing the Oklahoma Organization of Nurse Executives,
 - (3) a representative of the Oklahoma Nursing Home Association,
 - (4) a representative of the Oklahoma Hospital Association,
 - (5) a representative of the Oklahoma League for Nursing,
 - (6) a representative of the Oklahoma State Association of Licensed Practical Nurses,
 - (7) three Educators (a representative of the Oklahoma Directors of Practical Nursing Education; a representative of the Associate Degree Nursing Director's Council, and a representative of the Baccalaureate and Higher Degree Nursing Programs),
 - (8) a lay community representative, and
 - (9) a representative from the Physician Manpower Training Commission.
- (c) The role of the Nursing Scholarship Advisory Committee will be delineated by the Physician Manpower Training Commission.

SUBCHAPTER 5. CATEGORIES OF SCHOLARSHIPS

540:30-5-1. Matching Nursing Student Assistance Program

- (a) Scholarships granted under the Matching Nursing Student Assistance Program ~~shall~~will stipulate that a sponsor and

the Physician Manpower Training Commission provide equal dollar amounts for funding the scholarships. The maximum amounts that can be matched are \$750.00 per full-time semester for LPN program, \$1,250 per full-time semester for an ADN program, \$1,750.00 per full-time semester for the BSN program, and \$2,500.00 per full-time semester (up to 4 years) for MSN/DNP/Ph.D. program.

(b) Sponsors of nurse students may be hospitals, nursing homes, home health and hospice agencies, other health care delivery facilities, public agencies, corporations, private organizations, communities, foundations, trusts, or other entities who wish to apply for and, if approved, match an amount equal to fifty percent of the loan authorized by the Commission.

(c) Under the provisions of the Matching Nursing Student Assistance Program, a student may receive ~~a minimum total matching scholarship of \$1,000 (\$500/\$500), up to a maximum total matching scholarship of \$5,000 (\$2,500/\$2,500) an equal full scholarship amount from both the sponsor and the Physician Manpower Training Commission.~~ The monies are to be used for payment of tuition, required fees, equipment, uniforms, training materials, books, certification exams, and other educationally related expenses necessary for attendance at nursing school.

(d) An approximate guideline of seventy percent of all monies appropriated for the Physician Manpower Training Commission Nursing Student Assistance Program may be used for funding scholarships approved under the Matching Nursing Student Assistance Program. Approximately seventy percent of all funds designated for the Matching Nursing Student Assistance Program may be expended for nursing scholarships in Oklahoma communities with a population under 20,000 that meets the current definition of rural as determined by PMTC. A mix of 25% urban/70% rural should serve as a proportionate split of funds if possible.

(e) Scholarship recipients may carry out their service obligation by practicing full time as a licensed practical or registered nurse (excluding physician's offices, private duty practice, ~~research or non-patient based facilities, federally funded program or facility,~~ industrial and summer camp nursing) as agreed to by contract or with Commission approval.

(f) Scholarship recipients may carry out their service obligation by teaching in an accredited/approved Oklahoma nursing school (provided other Oklahoma Board of Nursing faculty qualifications are met).

(g) Scholarship receipts who become nurse practitioners may carry out their service obligation by practicing full time as a nurse practitioner at any ~~non-federal~~Oklahoma hospital, nursing home, state health facility, qualified rural health clinic, or ~~non-federal~~ hospital, private owned, or leased rural physician clinic.

(h) Receipts received from sponsors shall be deposited into and disbursed from a Commission revolving fund created by State Law in the State Treasury.

540:30-5-2. Non-Matching Nursing Student Assistance Program

- (a) State funds appropriated to the Nursing Student Assistance Program shall be used to grant scholarships under the

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Non-Matching Student Assistance Program. The maximum amounts that can be awarded are \$750.00 per full-time semester for LPN program, \$1,250 per full-time semester for an ADN program, \$1,750.00 per full-time semester for the BSN program, and \$2,500.00 per full-time semester (up to 4 years) for MSN/DNP/Ph.D. program.

(b) Scholarship recipients may carry out their service obligation by practicing full time as a licensed practical or registered nurse (excluding physician's offices, private duty practice, research or non-patient based facilities, ~~federally funded program or facility~~, industrial and summer camp nursing) as agreed to by contract or with Commission approval.

(c) Scholarship recipients may carry out their service obligation by teaching in an accredited/approved Oklahoma nursing school (provided other Oklahoma Board of Nursing faculty qualifications are met).

(d) Scholarship recipients who become nurse practitioners may carry out their service obligation by practicing full time as a nurse practitioner at any ~~non-federal~~ Oklahoma hospital, nursing home, state health facility, qualified rural health clinic, or ~~non-federal~~ hospital, private owned or leased rural physician clinic.

~~(e) Under the provisions of the Non-Matching Nursing Student Assistance Program, the student can receive a scholarship loan in the amount of \$2,500 for a given academic year, these monies to be paid for payment of tuition, required fees, training materials, books, and other educationally related expenses necessary for attendance at nursing school.~~

(e) In awarding grants for the Non-Matching Nursing Student Assistance Program, seventy percent of the designated monies may be earmarked for scholarship recipients who are deemed likely to return to a rural community to practice nursing.

SUBCHAPTER 7. ELIGIBILITY

540:30-7-1. Domicile

(a) For the purpose of obtaining a scholarship loan in accordance with the provisions of the Nursing Student Assistance Program, a person mustis required to have maintained domicile in the State of Oklahoma for at least twelve months immediately prior to a request for residency status and must be a citizen of the United States.

(b) In order to be eligible for classification as a legal resident under this program, an individual must establish physical presence in the State during such twelve month period not for the purposes of mere temporary residency incidental to enrollment in an educational program, or for application for a loan under this program.

(c) In some cases, it may be necessary to conduct an inquiry into the question of domiciliary intent. If so, an applicant may be requested to provide an appropriate application for analysis on forms to be made available by the Commission.

(d) A student mustis required to qualify for payment of in-state tuition and fees when attending a state supported school.

540:30-7-2. Acceptance in a course of study

(a) ~~An applicant~~ Qualifying applicants will have ~~must have~~ been unconditionally admitted as a student in an Oklahoma accredited/approved program of nursing study. Each applicant ~~must will~~ submit certification of acceptance and/or of being a student in good standing, academically and otherwise, by the Dean or Director of the nursing school he or she attends or plans to attend. This ~~must~~ certification is to be submitted as a part of the application process. Enrollment in basic courses prerequisite to and/or leading to a nursing program does not qualify an applicant.

(b) Part time nursing students may be considered on an individual basis as a qualified applicant. Evidence of progression within a nursing program ~~mustis to be shown~~ provided each semester.

(c) If already attending school, a student ~~must have been unconditionally promoted~~ is to submit documentation of unconditional promotion to the succeeding class with the exception of a part-time student who ~~must show~~ submits evidence of progression.

540:30-7-4. Criteria for selection of recipients

The following criteria shall be used for the selection of recipients of nursing scholarship loans:

- (1) Academic capability. Must maintain a 3.0 overall GPA.
- (2) Motivation to practice in a critical shortage area as defined by the Commission (with emphasis on rural practice).
- (3) Agreement to work in an institution, community or agency matching funding with the Commission (if appropriate).
- (4) Financial need - only if the number of applicants exceed the availability of funds.

SUBCHAPTER 9. APPLICATION PROCESS

540:30-9-1. Interview; application

(a) **Interview.** An interview with a representative of the Commission ~~is may~~ be required before an application is approved for a ~~matching~~ scholarship recipient.

(b) **Application form.** ~~An application form is provided with the confirmation of an interview.~~ The application form consists of:

- (1) General information.
- (2) Statement regarding financial needs.
- (3) Statement of professional goals.

(c) **Supporting information.** The following supporting application information may be required:

- (1) Certification of unconditional acceptance or promotion, whichever is applicable for the application.
- (2) A letter certifying unconditional acceptance and/or being a student in good standing by nursing school director.
- (3) A letter or transcript showing high school GPA or GED score for LPN students;

- (4) A letter or transcript showing ACT score, college and/or high school GPA for ADN, BSN, or MSN students;
- (5) Current Federal Income Tax form 1040, 1040A, or 1040EZ or proper certification if it is not necessary to file Federal Income Tax form. Dependent applicants must provide parent's income tax form in addition to their own form.

(d) **Date due.** The application form and supporting information ~~must be received by~~ will not be accepted after the applicable due date set by the Commission.

SUBCHAPTER 11. LOAN PROVISIONS

540:30-11-1. Repayment of discontinued loans

If a loan recipient for whatever reason becomes ineligible to continue participation in the program and repayment is required, then cash repayment (principal ~~and interest~~) is due within 90 days of the date of the Commission's written notification of ineligibility to the recipient.

540:30-11-2. Penalty for breach of contract

In the event that a loan recipient breaches the terms of the contract, he/she may be assessed liquidated damages which represent a reasonable estimate of the damage or loss of the State and/or the sponsor (if applicable). Said damages ~~shall be~~ not to exceed 100% of the principal.

540:30-11-3. Security for the loan

- (a) Each loan ~~must~~will be secured by a contract signed by the recipient and spouse if applicable.
- (b) Each loan ~~must~~will be secured by a contract signed by the recipient and a parent if the recipient is under 23 years of age and an unemancipated minor.
- (c) If a recipient shows little or no income, each loan ~~must~~will be secured by a contract signed by the recipient and the person providing support for the recipient.

540:30-11-5. Rate of interest ~~Fees~~

~~The rate of interest on a nursing scholarship loan will be 12% per annum. The yearly fee of 5% on the unpaid balance of the principal for each year with a minimum of \$50.00 for administrative finance costs. It will be due July 1st of each year that the loan is being serviced.~~

540:30-11-6. Suit for collection; attorney's fees and collection costs

If it becomes necessary for the Attorney General, on behalf of the State and Commission, to file suit for collection of a loan for notes, the makers of the note ~~shall~~will be responsible for attorney's fees and other costs or charges necessary for the collection of the balance due on the loan. Any collection under this Section will be deposited in the Revolving Fund. That portion representing a contribution(s) by a sponsor may be returned to the sponsor, placed to the sponsor's credit or

retained by the Physician Manpower Training Commission as is appropriate.

SUBCHAPTER 15. GENERAL ADMINISTRATIVE POLICIES

540:30-15-1. Installments to recipients

- (a) The Commission will pay the loan proceeds in monthly installments or in a lump sum if the NSAC so recommends.
- (b) Where applicable, the installments will be paid upon certification by an Officer of the school of satisfactory performance and transcript verifying GPA requirement and proof of enrollment for the following semester or registration for the NCLEX by the scholarship recipient at the end of each semester.

SUBCHAPTER 17. SERVICE OBLIGATION

540:30-17-2. Licensure examinations

- (a) Following the completion of required coursework, licensure examinations ~~must be written~~ will be completed as soon as possible after notification of eligibility;
- (b) If the recipient fails to pass the first two successive licensure examinations offered following the completion of required coursework, the recipient's note(s) become due and payable.

[OAR Docket #20-628; filed 7-16-20]

**TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM
CHAPTER 25. DEFERRED COMPENSATION**

[OAR Docket #20-591]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 9. Benefits
590:25-9-22. Coronavirus-related distributions [NEW]

AUTHORITY:

Oklahoma Public Employees Retirement System Board of Trustees; pursuant to 74 O.S. §§1701

ADOPTION:

May 21, 2020

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

July 1, 2020

EXPIRATION:

Effective through September 14, 2021, unless superseded by another rule or disapproved by the legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The Agency finds that an imminent peril exists to the preservation of the public health, safety, or welfare, or that a compelling public interest requires an emergency rule, amendment, revision, or revocation of an existing rule. These

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emergency rules are necessary to implement provisions of the Coronavirus Aid, Relief, And Economic Security Act (the "CARES Act").

GIST/ANALYSIS:

590:40-9-43 is necessary to allow participants of the SoonerSave defined contribution plan to request coronavirus-related distributions under the CARES Act.

CONTACT PERSON:

Dessa Baker-Inman (405) 858-6737

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 9. BENEFITS

590:25-9-22. Coronavirus-related distributions

Notwithstanding any other provisions of this Chapter, a Participant may request coronavirus-related distributions in accordance with Section 2202(a) of the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") which was signed into law on March 27, 2020.

[OAR Docket #20-591; filed 7-13-20]

TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM CHAPTER 40. DEFINED CONTRIBUTION SYSTEM

[OAR Docket #20-592]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 9. Defined Contribution 457(B) Plan
Part 7. Benefits
590:40-9-43. Coronavirus-related distributions [NEW]

AUTHORITY:

Oklahoma Public Employees Retirement System Board of Trustees; pursuant to 74 O.S. §§901, 909 and 935.3.

ADOPTION:

May 21, 2020

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

July 1, 2020

EXPIRATION:

Effective through September 14, 2021, unless superseded by another rule or disapproved by the legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The Agency finds that an imminent peril exists to the preservation of the public health, safety, or welfare, or that a compelling public interest requires an emergency rule, amendment, revision, or revocation of an existing rule. These emergency rules are necessary to implement provisions of the Coronavirus Aid, Relief, And Economic Security Act (the "CARES Act").

GIST/ANALYSIS:

590:40-9-43 is necessary to allow participants of the Pathfinder defined contribution plan to request coronavirus-related distributions under the CARES Act.

CONTACT PERSON:

Dessa Baker-Inman (405) 858-6737

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 9. DEFINED CONTRIBUTION 457(B) PLAN

PART 7. BENEFITS

590:40-9-43. Coronavirus-related distributions

Notwithstanding any other provisions of this Subchapter, a Participant may request coronavirus-related distributions in accordance with Section 2202(a) of the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") which was signed into law on March 27, 2020.

[OAR Docket #20-592; filed 7-13-20]

TITLE 777. STATEWIDE VIRTUAL CHARTER SCHOOL BOARD CHAPTER 10. STATEWIDE VIRTUAL CHARTER SCHOOLS

[OAR Docket #20-662]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. Statewide Virtual Charter School Sponsorship
777:10-3-4. Oversight and evaluation of virtual charter schools by the Statewide Virtual Charter School Board [AMENDED]

AUTHORITY:

70 O.S. § 3-145.8(D); Statewide Virtual Charter School Board

ADOPTION:

June 9, 2020

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

July 13, 2020

EXPIRATION:

Effective through September 14, 2021, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Statewide Virtual Charter School Board affirmed the finding of an emergency for the proposed rule changes at its public meeting on June 9, 2020 because the rule changes are necessary to address a compelling public interest.

More specifically, in 777:10-3-4, the amendments add a requirement for virtual charter schools authorized by the Statewide Virtual Charter School

Board to offer a student orientation as required by House Bill 2905, passed with an Emergency Clause, signed by the Governor and effective July 1, 2020.
GIST/ANALYSIS:

The proposed revisions to the rules add a requirement for virtual charter schools authorized by the Statewide Virtual Charter School Board to offer a student orientation and lists the components required on the orientation.

CONTACT PERSON:

Dr. Rebecca Wilkinson, Executive Director, (405) 522-3240, Rebecca.Wilkinson@svcsb.ok.gov.

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 3. STATEWIDE VIRTUAL CHARTER SCHOOL SPONSORSHIP

777:10-3-4. Oversight and evaluation of virtual charter schools by the Statewide Virtual Charter School Board

(a) **Oversight and annual review.** The Statewide Virtual Charter School will provide ongoing oversight of the charter schools through data and evidence collection, site visits, attendance of governing board meetings, school website compliance checks, and school performance reviews. At the end of each year, schools will be subject to an annual review consisting of a compilation of performance ratings and findings that will be shared with key stakeholders. The charter school will have fifteen (15) business days to respond to the annual review in writing and such response will become part of the record. A formal review of school performance may be conducted during the contract term, as applicable. The annual review report and any response will be posted to the SVCSB's website along with other information regarding each of the schools.

(b) **Performance framework.** The performance framework establishes accountability criteria for virtual charter schools authorized by the Statewide Virtual Charter School Board that assesses schools on their ability to operate as a sound, independent school that successfully serves all students in the areas of academic, financial, and organizational capacities. The board will use a checklist to determine if the charter school meets the standards or does not meet the standards for each criteria.

(1) Oklahoma performance measures will be used to assess the school's academic performance, including overall achievement, overall growth, subgroup achievement, subgroup growth and post-secondary readiness. Academic performance is measured via twenty-four (24) accountability indicators (see items A-X below). To meet the expectations, schools must demonstrate attainment of each indicator for each grade level and will be given weight accordingly. Indicators and measurements required to demonstrate that each standard has been met for achievement in each category are listed below. Sub-group measures will only be applicable if the school has a minimum of ten (10) students in the sub-group.

(A) Are students achieving proficiency on statewide assessments in Reading/English Language Arts

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(B) Are students achieving proficiency on statewide assessments in Math

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(C) Are students enrolled in the school for two or more consecutive academic years achieving proficiency on statewide assessments in Reading/English Language Arts?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(D) Are students enrolled in the school for two or more consecutive academic years achieving proficiency on statewide assessments in Math?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

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(E) Are students enrolled in the school for three or more consecutive academic years achieving proficiency on statewide assessments in Reading/English Language Arts?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(F) Are students enrolled in the school for three or more consecutive academic years achieving proficiency on statewide assessments in Math?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(G) Are students in the special education subgroup achieving proficiency on statewide assessments in Reading/English Language Arts?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(H) Are students in the special education subgroup achieving proficiency on statewide assessments in Math?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(I) Are students in the special education subgroup enrolled for two or more consecutive academic years achieving proficiency on statewide assessments in Reading/English Language Arts?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(J) Are students in the special education subgroup enrolled for two or more consecutive academic years achieving proficiency on statewide assessments in Math?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(K) Are students in the special education subgroup enrolled for three or more consecutive academic years achieving proficiency on statewide assessments in Reading/English Language Arts?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.

(L) Are students in the special education subgroup enrolled for three or more consecutive academic years achieving proficiency on statewide assessments in Math?

(i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or

(ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments

- is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- (M) Are students in the economically disadvantaged subgroup achieving proficiency on statewide assessments in Reading/English Language Arts?
- (i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or
 - (ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- (N) Are students in the economically disadvantaged achieving proficiency on statewide assessments in Math?
- (i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or
 - (ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- (O) Are students in the economically disadvantaged subgroup enrolled for two or more consecutive academic years achieving proficiency on statewide assessments in Reading/English Language Arts?
- (i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or
 - (ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- (P) Are students in the economically disadvantaged subgroup enrolled for two or more consecutive academic years achieving proficiency on statewide assessments in Math?
- (i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or
 - (ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- (Q) Are students in the economically disadvantaged subgroup enrolled for three or more consecutive academic years achieving proficiency on statewide assessments in Reading/English Language Arts?
- (i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or
 - (ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- (R) Are students in the economically disadvantaged subgroup enrolled for three or more consecutive academic years achieving proficiency on statewide assessments in Math?
- (i) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is equal to or above the state level of proficiency; or
 - (ii) The percentage of students scoring proficient or above at each grade level on the Oklahoma School Testing Program (OSTP) state assessments is improved 5% or greater each year over the baseline score established the first year of the charter contract term.
- (S) Based on state expectations for student graduation within four years, does the school meet the expectations for student graduation?
- (i) The school's most recent graduation rate is equal to or greater than the most recent graduation rate for the State of Oklahoma or
 - (ii) The school's most recent graduation rate increased 20% or more of the difference between the graduation rate of the baseline year and 100% over the past two years.
- (T) Based on the extended-year adjusted graduation rate, does the school meet the expectations for student graduation? Evidence indicates a majority of extended-year students graduating.
- (U) Did the school meet the expectation for graduating eligible seniors during the most recent year? The percent of eligible seniors enrolled on the first day of the school year and graduating in the current school year is equal to or greater than the current graduation rate for the State of Oklahoma.
- (V) Are the school's students participating in the American College Testing (ACT) college preparation assessment process? The most recent year's American College Testing (ACT) participation rate is equal

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to or greater than the most recent rate recorded for the State of Oklahoma.

(W) Does the school's student performance on the American College Testing (ACT) meet the state performance level? The school's most recent year's average composite American College Testing (ACT) score is equal to or greater than the most recent average score recorded for the State of Oklahoma.

(X) Are students benefiting from college and career readiness opportunities (i.e. college preparatory coursework, Career Technology programs, military service)? Evidence provides a profile of college and career readiness opportunities.

(Y) Is the school's college remediation rate equal to or less than the state remediation rate? The three-year average remediation rate of high school graduating classes indicates the school's college remediation rate is equal to or less than the state remediation rate.

(2) Fiscal viability of the schools is measured through audit findings, quarterly financial reports, and financial reporting. Financial performance is measured via six (6) accountability indicators (see items A-F below). To meet the expectations, schools must demonstrate attainment of each indicator. Indicators and measurements required to demonstrate that each standard has been met for achievement in each category are listed below.

(A) Did the most recent audit have findings? There were no findings of significant deficiencies, material noncompliance or known fraud on the school's most recent independent financial audit.

(B) Did any of the school's audits over the term of the contract have findings? There were no findings of significant deficiencies, material noncompliance or known fraud on any independent financial audits over the term of the charter contract?

(C) Did the school consistently submit appropriate quarterly financial reports over the most recent year? Appropriate reports were submitted in the Oklahoma Cost Accounting System (OCAS) format, on time, and indicating financial stability of the school.

(D) Did the school consistently submit appropriate quarterly financial reports over the term of the charter contract? Appropriate reports were submitted in the Oklahoma Cost Accounting System (OCAS) format, on time, and indicating financial stability of the school.

(E) Did the school consistently meet financial reporting expectations over the most recent year, as required by the State Department of Education and confirmed by the Office of Financial Accounting, Oklahoma Cost Accounting System (OCAS), and Audits? Financial reporting met expectations over the most recent year.

(F) Did the school consistently meet financial reporting expectations over the term of the charter contract, as required by the State Department of Education and confirmed by the Office of Financial Accounting, Oklahoma Cost Accounting System

(OCAS), and Audits? Financial reporting met expectations over the term of the charter contract.

(3) Organizational performance is measured by effective organizational structure, governance, record of compliance, attendance, recurrent enrollment, accreditation and student support. Organizational performance is measured via the accountability indicators listed below. To meet the expectations, schools must demonstrate attainment of each indicator. Indicators and measurements required to demonstrate that each standard has been met for achievement in each category are listed below.

(A) Is the school faithful to its mission and implementing key design elements within the approved charter contract? Evidence documents faithfulness to the school's mission and implementation of key design elements of school.

(B) Does the school follow appropriate procedures to ensure student access and equity? Data confirms appropriate procedures to ensure student access and equity.

(C) Does the school have approved and appropriate policies and procedures that ensure student and staff safety and success, and does the school communicate those policies and procedures to students/families and staff? Approved and appropriate policies and procedures are implemented and communicated.

(D) Does the school adhere to applicable state and federal laws and regulations? Evidence suggests the school adheres to state and federal laws and regulations.

(E) Does the school adhere to the terms of the charter contract? Evidence suggests the school adheres to the charter contract.

(F) Does a stable governing board exist? History of board stability exists.

(G) Does the governing board recruit, select, orient and train members with skills and expertise to enable them to govern the school appropriately? Board agendas and minutes document board member activities.

(H) Does the charter school comply with the Open Meeting Act and Open Records Act? The charter school consistently complies with requirements of the Open Meeting Act and Open Records Act.

(I) Does the charter school provide transparency through Statewide Virtual Charter School Board access to school records? The charter school has provided the Statewide Virtual Charter School Board with all requested school records.

(J) Does the educational service provider(s) provide transparency through Statewide Virtual Charter School Board access to school records? The charter school has provided the Statewide Virtual Charter School Board with all requested school records.

(K) Did the school consistently meet the reporting expectations as required by the State Department of Education during the most recent year? The State Department of Education confirms reporting expectations fulfilled.

(L) Did the school consistently meet the reporting expectations as required by the State Department of Education over the term of the charter contract? The State Department of Education confirms reporting expectations fulfilled.

(M) Did the school consistently meet the reporting expectations as required by the Statewide Virtual Charter School Board during the most recent year? Reporting expectations fulfilled as required - 90% or above in both on-time and accuracy categories.

(N) Did the school consistently meet the reporting expectations as required by the Statewide Virtual Charter School Board over the term of the charter contract? Reporting expectations fulfilled as required - 90% or above in both on-time and accuracy categories.

(O) Does the school website meet the standards for transparency and documentation as mandated by the Oklahoma School District Transparency Act and requested by the Statewide Virtual Charter School Board? The school has consistently met requirements for school website as mandated by the Oklahoma School District Transparency Act and requested by the Statewide Virtual Charter School Board.

(P) Did the school receive accreditation from the State Department of Education in the most recent year? The school received accreditation with no deficiencies noted from the State Department of Education in the most recent year.

(Q) Did the school receive accreditation from the State Department of Education over the term of the charter contract? The school received accreditation with no deficiencies noted from the State Department of Education over the term of the charter contract.

(R) Does the school meet the expectations for student attendance? Evidence documents the school met the expectations for student attendance.

(S) Does recurrent enrollment of students meet expectations? The school's student recurrent enrollment rate meets the expectations indicated by the methodology used for public schools in Oklahoma.

(T) Does the school provide support structures for students and families that are accessible twenty-four (24) hours per day and seven (7) days per week, such as teacher support, individualized learning plans, guidance/counseling program, online tutoring and technical support? Students and families have access to multiple support structures twenty-four (24) hours per day and seven (7) days per week.

(U) The charter school will submit up to three (3) data-driven goals and measurement criteria for approval by the SVCSB.

(i) Did the charter school meet the expectations of Goal One over the term of the charter contract?

(ii) Did the charter school meet the expectations of Goal Two over the term of the charter contract?

(iii) Did the charter school meet the expectations of Goal Three over the term of the charter contract?

(4) A Performance Framework Index will be calculated based on the following categories:

(A) Academic (A) Calculation - (Score) * (Weight) = A with at weight of 33.33%.

(B) Financial (F) Calculation - (Score) * (Weight) = F with at weight of 33.33%.

(C) Organizational (O) Calculation - (Score) * (Weight) = O with at weight of 33.33%.

(D) Performance Framework scores will guide reauthorization procedures.

(i) A Performance Framework Index (PFI) score of 80% or higher calculated over the course of the charter contract term will result in renewal of authorization for a five (5) year term should the governing board of the charter school choose to submit a letter requesting reauthorization.

(ii) A Performance Framework Index (PFI) score of 70% or higher calculated over the course of the charter contract term is expected. However, an application for renewal of authorization is required for consideration by the Statewide Virtual Charter School Board.

(iii) A Performance Framework Index (PFI) score of less than 70% calculated over the course of the charter contract term places the charter school at risk of non-approval of the renewal for authorization. An application for reauthorization is required for consideration by the Statewide Virtual Charter School Board.

(E) In the event data is not available, the Statewide Virtual Charter School Board will designate corresponding score with "Not Applicable".

(c) **Submission of school data.** To aid the Statewide Virtual Charter School Board in assessing whether the schools are meeting the expectations of the performance framework, schools are required to submit school data to the Statewide Virtual Charter School Board through an online data collection system.

(1) Schools must submit the requested documentation according to the instructions for the submission by the due date indicated in the online data collection system:

(A) Current charter contract and any amendments;

(B) Management contracts;

(C) Lease/purchase agreements;

(D) Annual budget;

(E) Audit documents (audit, response, corrective action);

(F) School performance review report response;

(G) Key design elements of school report and evidence of implementation;

(H) College preparation coursework report;

(I) Career technology programs report;

(J) Senior graduation report;

(K) Current inventory report;

(L) Quarterly financial statements;

Emergency Adoptions

- (M) Handbooks (Student/family handbook, Employee handbook);
 - (N) School calendar;
 - (O) Student support documentation;
 - (P) Internal assessment plan;
 - (Q) School policies (attendance, employment, enrollment/lottery);
 - (R) Current governing board rosters, including personal contact information;
 - (S) Insurance verification;
 - (T) Enrollment counts (initial, monthly and final);
 - (U) Surety bond verification;
 - (V) Accreditation application and status;
 - (W) First Quarter Statistical Report summary;
 - (X) Board meeting calendar, agendas, approved minutes and supporting board meeting documents;
 - (Y) Plan for Improvement (if applicable);
 - (Z) Final state aid and federal allocations;
 - (AA) ACT Profile Report;
 - (BB) Military service report;
 - (CC) Four (4) year cohort and extended year graduation rate documents;
 - (DD) Annual Statistical Report summary;
 - (EE) Strategic planning documents;
 - (FF) Oklahoma School Testing Program (OSTP) documentation;
 - (GG) Child counts;
 - (HH) Enrollment file;
 - (II) Estimate of Needs;
 - (JJ) Supplemental Estimate of Needs (if applicable);
 - (KK) Litigation documents;
 - (LL) State accountability report;
 - (MM) School organizational chart;
 - (NN) Comprehensive Exit Report;
 - (OO) Current by-laws;
 - (PP) Final Employee Compensation Report;
 - (QQ) College remediation data
 - (RR) Revenue and Expenditure Report
- (2) In the event submission through the online system is not possible, the school must hand-deliver hard-copy documentation to the office of the Statewide Virtual Charter School Board by the due date.
- (3) Failure to submit the documentation is grounds for termination of the contract.
 - (4) Receipt of document submissions does not necessarily indicate approval of the content of the data.
- (d) **School website compliance.** In order to aid in transparency, charter schools sponsored by the Statewide Virtual Charter School Board will be subject to website compliance checks at any time. The schools must have the following information available on its website:
- (1) Governing board members (board member information, and office held if any);
 - (2) Schedule of governing board meetings as submitted to the Oklahoma County Clerk;
 - (3) Board meeting agendas;
 - (4) Board meeting approved minutes;
 - (5) School accountability reports; and
 - (6) Financial documents or a link to the Oklahoma Cost Accounting System (OCAS), in compliance with Oklahoma statute.
- (e) **School orientation.** Each statewide virtual charter school shall develop a student orientation that must be completed by each student prior to final enrollment in the school. The school shall maintain a record of completion of orientation by each student. The orientation shall contain, at a minimum, the following components:
- (1) Enrollment requirements;
 - (2) Daily schedule and work expectations;
 - (3) School policies, manuals, resources for the student and family;
 - (4) Communication streams (website, school and teacher connection, school administration and governing board contact);
 - (5) Academic expectations;
 - (6) Assessment requirements;
 - (7) Social expectations;
 - (8) Technology management;
 - (9) Academic program management;
 - (10) Student support programs and services; and
 - (11) Programs specific to the school.

[OAR Docket #20-662; filed 7-22-20]

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

1:2020-20C.

EXECUTIVE ORDER 2020-20

On July 30th, the 35,740th case of a novel coronavirus ("COVID-19"), was confirmed in the State of Oklahoma. As noted in a previous Executive Order, the United States Centers for Disease Control and Prevention has identified the potential public health threat posed by COVID-19 as "high" both globally and in the United States. In addition, on March 14, 2020, the President of the United States declared a national health emergency in the United States as a result of the national spread of COVID-19. On March 15, 2020, I issued Executive Order 2020-07, which was last amended in Eighth Amended Executive Order 2020-07, declaring an emergency caused by the impending threat of COVID-19 to the people of this State and the public's peace, health, and safety, and I have issued a series of Executive Orders over the last few months addressing this health crisis, the last of which, Amended Executive Order 2020-20, was issued on June 12, 2020. This health crisis still exists, and still needs to be addressed in various ways by Executive Order.

As COVID-19's impact continues to affect our State and its citizens, it is important to continue to take measures to protect all Oklahomans against this threat. Therefore, I believe, after consultation with numerous health experts within my administration, it is still necessary to provide for the rendering of mutual assistance among the State and political subdivisions of the State and to cooperate with the Federal government with respect to carrying out emergency functions during the continuance of the State emergency pursuant to the provisions of the Oklahoma Emergency Management Act of 2003.

In view of the foregoing, I, J. Kevin Stitt, Governor of the State of Oklahoma, pursuant to the power vested in me by Section 2 of Article VI of the Oklahoma Constitution hereby declare and order the following:

1. here is hereby declared an emergency caused by the threat of COVID-19 to the people of this State and the public's peace, health, and safety. The counties included in this declaration are:

All 77 Oklahoma Counties

2. The State Emergency Operations Plan has been activated, and resources of all State departments and agencies available to meet this emergency are hereby committed to the reasonable extent necessary to prepare for and respond to COVID-19 and to protect the health and safety of the public. These efforts shall be coordinated by the Director of the Department of Emergency Management with comparable functions of the federal government and political subdivisions of the State.

3. State agencies, in responding to this emergency, may make necessary emergency acquisitions to fulfill the purposes of this declaration. If using a P-Card to make such acquisitions, agencies may purchase the necessary acquisitions without regard to the current P-Card policy limitation of \$5,000.00 purchase limit. Agencies may make the necessary emergency acquisitions without the requirement to follow bidding requirement/limitations on such emergency acquisitions, without the need to purchase from State Use Vendors, or to purchase from mandatory Statewide contracts. Such necessary emergency purchases shall be capped at \$250,000.00 per transaction. All such purchases must be readily identifiable as such, as following the conclusions of this threat, all such necessary emergency acquisitions will be audited to determine if they were made for emergency purposes.

4. Effective immediately, a moratorium is placed on all out-of-state travel for all employees and officers of agencies that is paid for, in whole or in part, by the State of Oklahoma. This moratorium shall apply to all travel expenses not already incurred as of the date of this Order. Any state employee or officer seeking an exception to this moratorium may submit a written request to the Governor, who shall have the sole discretion to approve or deny the request.

5. State agencies, in responding to this emergency, may employ additional staff without regard to the classification requirements of such employment.

6. The requirement in Amended Executive Order 2019-3 that the Chief Administrative Officer request and obtain approval from the Cabinet Secretary for an exemption to the personnel freeze for agencies under the Secretary of Health and Mental Health shall be waived.

7. State agencies shall continue to follow guidance for interaction with the public provided by the Oklahoma Department of Health.

Executive Orders

8. Emergency responders employed by the State of Oklahoma who are correctional officers, law enforcement officers, and fire personnel shall not be excluded from the application of and benefits under the Emergency Paid Sick Leave Act of the Families First Coronavirus Response Act (FFCRA) if:

- a. They are subject to a coronavirus quarantine or isolation order;
- b. They have been advised by a healthcare provider to self-quarantine due to coronavirus concerns; or
- c. They are experiencing symptoms of coronavirus and are seeking a medical diagnosis.

In addition, I direct as follows:

1. All State agencies shall continue to transmit a clear delegation of authority for state agency directors and designate an Emergency Management Liaison.

2. All State agencies shall establish and, if necessary, implement a remote work policy that balances the safety and welfare of state employees with the critical services they provide.

3. All State agencies shall encourage Oklahomans interacting with agency services to utilize online options whenever possible.

4. All State agencies shall ensure continued compliance with Executive Order 2019-13, which limits non-essential out-of-state travel.

5. All State agencies shall promulgate any emergency rules necessary to respond to the emergency and to comply with the directives contained herein.

6. All occupational licenses issued by any agency, board, or commission of the State of Oklahoma that expire during this emergency shall be extended. All occupational licenses extended during this Order will expire fourteen (14) days following the withdrawal or termination of this Order.

7. Any medical professional who holds a license, certificate, or other permit issued by any state that is a party to the Emergency Management Compact evidencing the meeting of qualifications for the practice of certain medical services, as more particularly described below, shall be deemed licensed to practice in Oklahoma so long as this Order shall be in effect, subject to the following conditions:

a. This shall only apply to Medical (MD) and Allied Licenses issued by the Board of Medical Licensure and Supervision, Licenses issued by State Board of Osteopathic Examiners, and Licenses and Certificates issued by the Board of Nursing, all three shall collectively be referred to as "Boards";

b. Any medical professional intending to practice in Oklahoma pursuant to this Order, hereinafter referred to as "Applicant," shall first apply with and receive approval from appropriate Board;

c. It is the responsibility of each Board to verify the license status of any applicant and, upon verification of good standing, shall issue a temporary license to practice within this State; and

d. Any applicant licensed under this Order shall be subject to the oversight and jurisdiction of the licensing Board, which includes the ability of the Board to revoke said license and to initiate any administrative or civil proceeding related to any alleged misconduct of the applicant.

8. Hospitals and Physician Clinics (collectively referred to as "hospitals") operating in the State shall cooperate with and respond to all requests for critical data from the Oklahoma State Department of Health ("OSDH"), as applicable to the services they provide. This shall include, but will not be limited to, the daily submission, no later than noon, of critical data in a manner and format prescribed by OSDH. Critical Data shall include, but not be limited to:

a. The number of available (i) ICU beds, (ii) medical surgery beds, (iii) operating room beds, (iv) pediatric beds, (v) PICU beds, (vi) ventilators, (vii) anesthesia machines capable of patient ventilation, (viii) ventilator connecting circuits, (ix) patient interfaces, (x) negative flow rooms, (xi) and overall occupancy status;

b. COVID-19 Test Availability, as measured by the number of COVID-19 testing kits available for use at the hospital;

c. The number of (i) positive patients and persons under investigation in the hospital receiving treatment and (ii) positive patients and persons under investigation sent home for self-quarantine; and

d. Personal Protective Equipment stock on hand.

9. Every public or private entity that is utilizing, or has utilized, an FDA-approved test, including an emergency use authorization test, for human diagnostic purposes of COVID-19, shall submit to Oklahoma State Department of Health (OSDH), as well as to the local health department, daily reports of all test results, both positive and negative, the number of test supplies ordered, the number of test supplies available, the number of samples/specimens received and pending processing, and timeframe of test completion, for all days from the date hereof forward. In addition, OSDH shall promptly share this information with the CDC.

10. The OSDH shall provide daily an aggregated summary of the information requested in the preceding paragraphs to the Office of the Governor by 3:00 p.m.

11. Telemedicine shall be used to maximum potential and shall be allowed for non-established patients for the purposes of the COVID-19 response. The preexisting patient relationship requirement for telemedicine, as required by 59 O.S. § 478.1, only applies to the prescribing of opiates and other controlled dangerous substances. 59 O.S. § 478.1 already allows the physician to see patients using telemedicine without the prior establishment of the physician patient relationship. Nothing in this Order shall waive 59 O.S. § 478.1 (C) for the purpose of prescribing opiates and other controlled dangerous substances reference therein.

12. The requirement that an individual be unemployed for a waiting period of one (1) week before benefits are paid, as required by 40 O.S. § 2-206, is hereby waived.

13. Oklahoma State regulations requiring Clinical Laboratory Improvement Amendment (CLIA) certification for testing laboratories are hereby suspended for the universities named below and for the narrow purposes described herein. During this suspension, laboratories operated by or through the University of Oklahoma, including the OU Medicine Laboratory, and Oklahoma State University are authorized to conduct testing and testing-related activities in response to the COVID-19 pandemic. Further, the Oklahoma Commissioner of Health, acting through and on behalf of OSDH, is hereby authorized to contract with the Board of Regents for the Oklahoma Agricultural and Mechanical Colleges, the Board of Regents for the University of Oklahoma, and/or their constituent agencies and the OU Medicine Laboratory, to perform laboratory tests and test-related activities, without regard to CLIA certification requirements, as necessary to detect and report COVID-19 infection in compliance with applicable law. The Commissioner of Health is authorized to negotiate and execute any and all agreements and terms necessary to execute and implement this provision.

14. All citizens of Oklahoma (but particularly adults over the age of sixty-five (65) and people of any age who have serious underlying medical conditions collectively referred to as "vulnerable individuals") are encouraged to regularly consult the Oklahoma State Department of Health's COVID-19 Alert System (www.coronavirus.health.ok.gov/covid-19-alert-system) and follow the Guidelines published therein for their County of residence. Vulnerable individuals are strongly encouraged to follow the "General Guidelines for High-Risk Individuals" on the Department of Health's Alert System website described above. For those vulnerable individuals living in Counties color-coded Orange or Red on the Department of Health's Alert System website, such individuals should consider staying in their home or place of residence except for working in a critical infrastructure sector, and conducting essential errands. Essential errands shall mean those errands which are critical to everyday life and includes obtaining medication, groceries, gasoline, and visiting medical providers. Vulnerable individuals are also encouraged to use delivery and/or curbside services whenever available.

15. Unless otherwise specified in the Open Up and Recover Safely (OURS) Plan on the Oklahoma Department of Commerce website, individuals should follow Centers for Disease Control (CDC) guidelines for social distancing and gathering in groups.

16. All businesses should adhere to the statewide Open Up and Recover Safely (OURS) Plan as provided on the Oklahoma Department of Commerce website.

17. Until June 15, 2020, except for end-of-life situations, visitors are prohibited from entering and visiting patients and residents at nursing homes, long-term care facilities, and retirement homes. On and after June 15, 2020, visitation, outings, group meals and communal dining shall be in accordance with guidance issued by the Oklahoma State Department of Health based on recommendations from the Centers for Disease Control and Prevention.

18. All delivery personnel including package, floral, and food delivery shall, at the request of a hospital, clinic, long-term care facility, or childcare facility submit to a screening prior to delivering goods. Such screening shall include a temperature check and may include a short questionnaire about potential exposure. Additionally, package delivery drivers must take their own temperature daily and shall not deliver packages if it registers over 100.4 degrees Fahrenheit. Questionnaires shall include questions about recent travel to areas with significant community spread and personal contact with individuals who have tested positive for COVID-19.

19. As supporting front-line healthcare workers is essential to our battle against COVID-19, front-line healthcare workers and their children, who have not tested positive for COVID-19 and are not otherwise exhibiting the symptoms thereof, shall not - simply because they are healthcare workers or children of healthcare workers - be discriminated against in housing or childcare services.

20. Any statutory or rule-based time requirements for completing training and becoming certified as a peace officer for duly appointed or elected peace officers during the existence of this emergency are hereby waived during the period of the emergency and for thirty days after the emergency is declared to be over.

21. Any requirements that county reserve deputies, municipal reserve officers, or other duly appointed reserve peace officers in this State be CLEET-certified prior to serving in an individual capacity or be accompanied by a CLEET-certified peace officer prior to becoming CLEET-certified are hereby waived during the period of the emergency and for thirty days after the emergency is declared to be over. Any such reserve deputy, municipal reserve officer, or other duly appointed reserve peace officer must be commissioned and authorized by his or her appointing agency's head or designee before being allowed to work as a peace officer under this provision.

Executive Orders

22. I hereby direct all persons who enter the State of Oklahoma from another state or country to follow CDC travel guidelines found at <https://coronavirus.health.ok.gov/travel>.

23. The OSDH shall work with the Oklahoma State Department of Education to create a plan for, at a minimum, the optional monthly COVID-19 testing of every Teacher, as defined by 70 O.S. § 1-116, and Support Employee, as defined by 70 O.S. § 1-116. The Plan should prioritize the testing of people physically working in school buildings and may include creating private-public partnerships to increase testing capacity and coordinating with County Health Departments and other stakeholders, as necessary. The Plan shall be finalized by August 21, 2020. Neither the Plan nor this provision shall limit the ability of a local board of education to provide for additional testing.

24. I direct the Oklahoma Department of Agriculture, Food, and Forestry as follows:

a. Assist in the depopulation of any animals that are unable to be processed at available processing facilities due to COVID-19.

b. Assist in the disposal of animal carcasses resulting from the euthanasia in a manner that protects the environment, does not create a public health hazard, does not result in contamination of public or private drinking water supplies, and ensures watersheds and groundwater are adequately protected pursuant to 2 O.S. § 20-10(B).

c. Utilize all necessary equipment and manpower available and to freely move the equipment and manpower across state lines in cooperation with bordering states.

d. Cooperate with appropriate agencies, including but not limited to Oklahoma Department of Transportation, Oklahoma Department of Public Safety, and Oklahoma Department of Environmental Quality to ensure roadways are protected and all solid wastes are managed and disposed of appropriately.

e. Ensure ease of licensing, including the use of umbrella licensing, for vehicles utilized to move animal carcasses.

Further, I hereby order the temporary suspension of the following as they apply to vehicles in the support efforts:

1. The cost and fees of oversize/overweight permits required of carriers whose sole purpose is transportation of materials, equipment, and supplies used for recovery/relief efforts which require an overweight permit under Title 47 of Oklahoma statutes.

2. By execution of this Order, motor carriers and drivers providing direct assistance in support of relief efforts related to the COVID-19 outbreaks are granted emergency relief from Parts 390 through 399 of Title 49 Code of Federal Regulations,

except as restricted herein. Direct assistance means transportation and other relief services provided by a motor carrier or its driver(s) incident to the immediate restoration of essential services, such as medical care, or essential supplies such as food, related to COVID-19 outbreaks during the emergency.

a. This Emergency Declaration provides regulatory relief for commercial motor vehicle operations that are providing direct assistance in support of emergency relief efforts related to the COVID-19 outbreaks, including transportation to meet immediate needs for: (1) medical supplies and equipment related to the testing, diagnosis and treatment of COVID-19; (2) supplies and equipment necessary for community safety, sanitation, and prevention of community transmission of COVID-19 such as masks, gloves, hand sanitizer, soap and disinfectants; (3) food for emergency restocking of stores; (4) equipment, supplies and persons necessary to establish and manage temporary housing, quarantine, and isolation facilities related to COVID-19; (5) persons designated by Federal, State or local authorities for medical, isolation, or quarantine purposes; (6) persons necessary to provide other medical or emergency services, the supply of which may be affected by the COVID-19 response; (7) fuels and petroleum products (to include fuel oil, diesel oil, gasoline, kerosene, propane, and liquid petroleum); and (8) livestock, poultry, feed for livestock and poultry, and crops and other agricultural products ready to be harvested.

b. Direct assistance does not include routine commercial deliveries, or transportation of mixed loads that include essential supplies, equipment and persons, along with supplies, equipment and persons that are not being transported in support of emergency relief efforts related to the COVID-19 outbreaks.

c. Direct assistance terminates when a driver or commercial motor vehicle is used in interstate commerce to transport cargo or provide services that are not in support of emergency relief efforts related to the COVID-19 outbreaks or when the motor carrier dispatches a driver or commercial motor vehicle to another location to begin operations in commerce. 49 CFR 390.23(b). Upon termination of direct assistance to emergency relief efforts related to the COVID-19 outbreaks, the motor carrier and driver are subject to the requirements of 49 CFR Parts 390 through 399, except that a driver may return empty to the motor carrier's terminal or the driver's normal work reporting location without complying with Parts 390 through 399. However, if the driver informs the motor carrier that he or she needs immediate rest, the driver must be permitted at least 10 consecutive hours off duty before the driver is required to return to the motor carrier's terminal or the driver's normal reporting location. Once the driver has returned to the terminal or other location, the driver must be relieved of all duty and responsibilities and must receive a minimum of 10 hours off duty if transporting property, and 8 hours if transporting passengers.

3. The requirements for licensing/operating authority as required by the Oklahoma Corporation Commission.

4. The requirements for licensing/registration authority as required by the Oklahoma Tax Commission.

Nothing contained in this Order shall be construed as an exemption from the Controlled Substance and Alcohol Use and testing requirements. (49 C.F.R. part 382), the Commercial Driver License requirements (49 C.F.R. part 383), the Financial Responsibilities requirements (49 C.F.R. part 387), or any other portion of the regulations not specifically identified herein. Motor carriers that have an Out-of-Service Order in effect cannot take advantage of the relief from regulation that this declaration provided.

This Order shall be effective until the end of thirty (30) days after the filing of this Order.

Copies of this Executive Order shall be distributed to the Director of Emergency Management, the Oklahoma State Health Commissioner, the Commissioner of the Department of Public Safety, the Director of the Office of Management and Enterprise Services, the Oklahoma Tax Commission, the Oklahoma Corporation Commission who shall cause the provisions of this Order to be implemented by all appropriate agencies of State government.

IN WITNESS WHEREOF, I have set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, this 30th day of July, 2020.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

J. Kevin Stitt

ATTEST:
Michael Rogers
Secretary of State

[OAR Docket #20-729; filed 7-30-20]

1:2020-24.

EXECUTIVE ORDER 2020-24

On July 9, 2020, the Supreme Court of the United States held the Muscogee (Creek) reservation was never disestablished in the State of Oklahoma. As it stands, this decision alters the State's legal jurisdiction and law enforcement capabilities on potentially a significant portion of eastern Oklahoma, creating uncertainty for many Oklahomans in numerous areas of life and law.

In view of the magnitude of the potential consequences to the State of Oklahoma, after consultation with members of the Cabinet, members of the legislature, and civic and business leaders from across the State, I believe a commission is needed

to lead the State's efforts in response to the recent Supreme Court decision.

Therefore, I, J. Kevin Stitt, Governor of the State of Oklahoma, pursuant to the power vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution hereby order the formation of ***The Oklahoma Commission on Cooperative Sovereignty*** to address concerns and make recommendations to the State and the United States Congress in light of the recent Supreme Court decision in *McGirt v. Oklahoma*.

The Commission is hereby ordered to:

1. Review and evaluate the implications of the Supreme Court decision in *McGirt* for the future of Oklahoma's economy and general welfare;

2. Assess and propose recommendations in specific areas including agricultural, criminal and civil jurisdiction, economic policies, taxation, and land and trust policies;

3. Collaborate with Tribal leaders to develop responses that reflect the sovereign-to-sovereign relationship between the State and Tribal Nations;

4. Provide a forum to hear from, and engage with, leaders from various sectors of the Oklahoma economy, local communities, Oklahoma's Indian Tribes, and Oklahoma's residents so they may share their concerns and opinions, which will contribute to and help inform the Commission's policy recommendations;

5. Work with the Office of the Governor to provide guidance to the Oklahoma congressional delegation on the appropriate federal response; and

6. Issue a report with recommendations to the Governor.

The Commission will be composed of leaders from various spheres including law, government, and business. Invitations to participate as a member of the Commission may be extended to a member (or designee) of Oklahoma's congressional delegation, a member of the State House of Representatives, a member of the State Senate, a representative of the Oklahoma Attorney General's office, a member of the District Attorneys Council, and at least one representative of one of Oklahoma's federally recognized Indian Tribes. The Governor, or his designee will chair the Commission.

In addition to the foregoing, I hereby order any State agency, board, or commission that believes it may be impacted by the *McGirt* decision to submit a Notice of Potential Impact to the Chair of the Commission by August 28, 2020. Said Notice only needs to include the name of the agency, preferred point of contact, and contact information. If an agency, board, or commission does not anticipate any impact then no action is necessary.

Executive Orders

Any agency, board, or commission that submits a Notice shall also submit a more detailed Report of Potential Impact by September 30, 2020. The Report shall specify the area(s) in which the agency anticipates an impact, the nature and extent of the impact, including fiscal impact, and what, if any, steps it has taken, or suggests be taken, to mitigate the potential impact.

Staff support and research, as needed and as requested, will be provided by those State offices, boards, commissions and agencies best positioned to provide the same.

This Executive Order shall be forwarded to the Speaker of the Oklahoma House of Representatives, the President Pro Tempore of the Oklahoma Senate, the Attorney General of the State of Oklahoma, to the members of the Governor's Cabinet, and to the administrative heads of all State agencies, boards, and commissions, who shall cause the provisions of the Order to be implemented.

IN WITNESS WHEREOF, I have set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma this 20th day of July, 2020.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

J. Kevin Stitt

ATTEST:
Michael Rogers
Secretary of State

[OAR Docket #20-648; filed 7-20-20]
