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Agency	Title	Agency	Title
Oklahoma Department of CAREER and Technology Education (Formerly: Oklahoma Department of VOCATIONAL and Technical Education)	780	Oklahoma WHEAT Commission	795
Oklahoma WATER Resources Board	785	Department of WILDLIFE Conservation	800
Board of Regents of WESTERN Oklahoma State College (<i>exempted</i> <i>11-1-98</i>)	790	WILL Rogers and J.M. Davis Memorials Commission	805
		Oklahoma WORKERS' Compensation Commission	810

Notices of Rulemaking Intent

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

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

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

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

[OAR Docket #19-799]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

210:10-1-4. Length of term [AMENDED]

SUMMARY:

The rule that addresses requirements for the length of a school year is being updated to reflect changes in law. 70 O.S. § 1-109 provides that beginning with the 2021-2022 school year, public schools must be in session for not less than one thousand eighty (1,080) hours with a minimum of one hundred sixty-five (165) days of instruction each school year. A waiver of the 165-day minimum for school academic calendars is authorized provided a school district "meets the requirements established by the State Board of Education." Pursuant to Senate Bill 441 (2019), the State Board of Education is directed to promulgate rules establishing the minimum guidelines for student performance and cost savings for school districts that wish to apply for a waiver of the 165-day minimum school year. The proposed rule amendment outlines these eligibility guidelines for an alternate length school year waiver, developed through a process involving stakeholder input and alignment with Oklahoma's *Every Student Succeeds Act* (ESSA) state plan.

AUTHORITY:

State Board of Education; 70 O.S. § 3-104; 70 O.S. § 1-109

COMMENT PERIOD:

Written comments on the proposed rule(s) will be accepted from November 15, 2019 until 4:30 p.m. on Monday, December 16, 2019.

Written comments in electronic form will be accepted during the open public comment period via email at rules@sde.ok.gov or by fax at (405) 522-6256. During the open public comment period, written comments may also be hand delivered to the agency during regular business hours or via regular mail to the individual at the address shown below under "Contact Person."

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

PUBLIC HEARING:

A public hearing is scheduled for 2:00 p.m. on Monday, December 16, 2019, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Persons wishing to speak must sign in at the door of the State Board Room prior to the start of the hearing. Time limitations may be imposed on oral presentations to ensure that all persons who desire to make oral comments will have an opportunity to do so.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

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

RULE IMPACT STATEMENT:

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

CONTACT PERSON:

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

[OAR Docket #19-799; filed 10-25-19]

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

[OAR Docket #19-800]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

Notices of Rulemaking Intent

PROPOSED RULES:

Subchapter 13. Student Assessment
210:10-13-25. Determination of the chronic absenteeism indicator [NEW]

SUMMARY:

The Oklahoma school accountability system developed in accordance with the *Every Student Succeeds Act* (ESSA) is required under 70 O.S. § 1210.545 to include an indicator on the school report card associated with chronic absenteeism. In school years 2017-18 and 2018-19, the accountability statute provided that through administrative rules the State Board of Education would oversee a process for considering schools' requests for medical exemptions from chronic absenteeism for students with significant qualifying medical conditions. Pursuant to House Bill 1988 (2019), the rule mandating placing medical exemption authority at the state level was revoked, and the accompanying rule is being revoked as well. This new proposed rule authorizes school districts to develop chronic absenteeism medical exemption policies at the local level, which are to be developed in accordance with the guidelines laid out in the rule.

AUTHORITY:

State Board of Education; 70 O.S. § 3-104; 70 O.S. § 1210.545

COMMENT PERIOD:

Written comments on the proposed rule(s) will be accepted from November 15, 2019 until 4:30 p.m. on Monday, December 16, 2019.

Written comments in electronic form will be accepted during the open public comment period via email at rules@sde.ok.gov or by fax at (405) 522-6256. During the open public comment period, written comments may also be hand delivered to the agency during regular business hours or via regular mail to the individual at the address shown below under "Contact Person."

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

PUBLIC HEARING:

A public hearing is scheduled for 2:00 p.m. on Monday, December 16, 2019, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Persons wishing to speak must sign in at the door of the State Board Room prior to the start of the hearing. Time limitations may be imposed on oral presentations to ensure that all persons who desire to make oral comments will have an opportunity to do so.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

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

the State Department of Education Legal Services website at: <http://ok.gov/sde/administrative-rules>

RULE IMPACT STATEMENT:

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

CONTACT PERSON:

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

[OAR Docket #19-800; filed 10-25-19]

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

[OAR Docket #19-801]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Transportation
210:30-5-8. School bus driver certification [AMENDED]

SUMMARY:

The rule that establishes requirements for school bus driver certification is being amended to allow for Commercial Driver License (CDL) holders with current valid CDL licenses issued in other states to be eligible to apply for Oklahoma school bus driver certification. The proposed amendment will also allow for physicians licensed in other states to sign the annual health certificates required for school bus drivers, and for Department of Veterans Affairs (VA) physicians to sign health certificates for school bus drivers who are veterans of the United States Armed Forces.

AUTHORITY:

State Board of Education; 70 O.S. § 3-104; 70 O.S. § 9-101 et seq.

COMMENT PERIOD:

Written comments on the proposed rule(s) will be accepted from November 15, 2019 until 4:30 p.m. on Monday, December 16, 2019.

Written comments in electronic form will be accepted during the open public comment period via email at rules@sde.ok.gov or by fax at (405) 522-6256. During the open public comment period, written comments may also be hand delivered to the agency during regular business hours or

via regular mail to the individual at the address shown below under "Contact Person."

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

PUBLIC HEARING:

A public hearing is scheduled for 2:00 p.m. on Monday, December 16, 2019, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma. Persons wishing to speak must sign in at the door of the State Board Room prior to the start of the hearing. Time limitations may be imposed on oral presentations to ensure that all persons who desire to make oral comments will have an opportunity to do so.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

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

RULE IMPACT STATEMENT:

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

CONTACT PERSON:

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

[OAR Docket #19-801; filed 10-25-19]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 641. INDIVIDUAL AND SMALL PUBLIC ON-SITE SEWAGE TREATMENT SYSTEMS**

[OAR Docket #19-798]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions
252:641-1-1 [AMENDED]

252:641-1-2 [AMENDED]
252:641-1-3 [AMENDED]
252:641-1-4 [AMENDED]
252:641-1-5 [AMENDED]
Subchapter 3. Soil Tests
252:641-3-1 [AMENDED]
252:641-3-2 [AMENDED]
252:641-3-4 [AMENDED]
Subchapter 5. Building Sewer and Collection Systems
252:641-5-1 [AMENDED]
252:641-5-2 [REVOKED]
Subchapter 7. Septic Tanks
252:641-7-1 [AMENDED]
252:641-7-3 [AMENDED]
Subchapter 9. Pump Tanks
252:641-9-1 [AMENDED]
Subchapter 10. Aerobic Treatment Systems
252:641-10-1 [AMENDED]
252:641-10-2 [AMENDED]
252:641-10-3 [AMENDED]
Subchapter 12. Dispersal Fields
252:641-12-2 [AMENDED]
252:641-12-3 [AMENDED]
252:641-12-5 [AMENDED]
252:641-12-6 [AMENDED]
252:641-12-7 [AMENDED]
Subchapter 15. Lagoons
252:641-15-1 [AMENDED]
252:641-15-5 [AMENDED]
252:641-15-6 [AMENDED]
Subchapter 21. Certification for On-site Sewage Treatment System Installers
252:641-21-2.1 [AMENDED]
252:641-21-3 [AMENDED]
252:641-21-12 [AMENDED]
Subchapter 22. Certification for ~~Persons who Perform Soil Profile~~ ~~Profilers~~ ~~Descriptions~~
252:641-22-2 [AMENDED]
252:641-22-3 [AMENDED]
252:641-22-4 [AMENDED]
252:641-22-5 [AMENDED]
Subchapter 23. Fees
252:641-23-2 [AMENDED]
252:641-23-3 [AMENDED]
252:641-23-4 [AMENDED]
252:641-23-5 [NEW]
Appendix C. Pipe Specifications for On-site Sewage Treatment Systems [REVOKED]
Appendix C. Pipe Specifications for On-site Sewage Treatment Systems [NEW]
Appendix E. Horizontal Separation Distance Requirements for On-site Sewage Treatment Systems [REVOKED]
Appendix E. Horizontal Separation Distance Requirements for On-site Sewage Treatment Systems [NEW]
Appendix F. Estimated Average Daily Flow for Small Public On-site Sewage Treatment Systems [REVOKED]

Notices of Rulemaking Intent

Appendix F. Estimated Average Daily Flow for Small Public On-site Sewage Treatment Systems [NEW]

Appendix M. Examples of Trench Installation [REVOKED]

Appendix M. Examples of Trench Installation [NEW]

SUMMARY:

The gist of the rule that the Department is proposing is to: (1) clarify the definitions of "Sewage", (2) clarify ownership as it applies to on-site systems, (3) establish a date that the percolation test method will no longer be accepted for the design and sizing of on-site sewage treatment system, (4) remove the building sewer construction requirements and reference the most current adoption of the Oklahoma Plumbing Code, (5) require the installation of an access manhole over the septic tank inlet baffle, (6) include language to allow the use of aerobic treatment systems for commercial small public facilities, increase the overall installation depth of the systems, and clarify the maintenance requirements, (7) amend the construction requirements for ET/A system to allow for a depth of installation range from 18-24 inches, (8) amend the drip installation requirements to include a daily pumping timeframe, clarify the drip pipe spacing requirements, and require the installation of a flow meter in the dispersal field, (9) add closure requirements for lagoons and require signage for all small public lagoons, (10) add language that defines the timeframe a passing test score is valid as it applies to Certified Installers and Certified Soil Profilers and define the timeframe records are to be retained, (11) include language that references OAC 252:4-7 that addresses the refunding of permit fees, and (12) make other minor clarifications and corrections.

AUTHORITY:

Environmental Quality Board; 27A O.S., §§ 2-2-101, 2-2-201, 2-6-402, and 2-6-403; and 59 O.S., § 1158.

COMMENT PERIOD:

Written comments may be submitted from November 15, 2019, through December 16, 2019 to Nicholas Huber, ECLS, Department of Environmental Quality, 707 N. Robinson, P.O. Box 1677, Oklahoma City, OK 73101-1677, or by email to nicholas.huber@deq.ok.gov. Oral comments may be made at the Water Quality Management Advisory Council meeting on January 7, 2020, and the Environmental Quality Board meeting on February 21, 2020.

PUBLIC HEARING:

A public hearing will be held before the Water Quality Management Advisory Council on January 7, 2020, at 2:00 p.m. at the Department of Environmental Quality offices, First Floor, 707 N. Robinson, Oklahoma City, OK 73102. A public hearing will be held before the Environmental Quality Board on February 21, 2020, at the Department of Environmental Quality offices, First Floor, 707 N. Robinson, Oklahoma City, OK 73102.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities affected by the proposed rules provide to DEQ (during the comment period) the increase (in dollar amounts if possible) in the level of indirect costs (e.g., reporting, record keeping, equipment,

construction, labor, professional services, revenue loss), or other costs expected to be incurred due to compliance with the proposed rules.

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the contact person, reviewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, during normal business hours (8:00 am - 4:30 pm Monday through Friday) or reviewed online at https://www.deq.ok.gov/wp-content/uploads/deqmain/resources/252641_IndividualandSmallPublicOn-SiteSewageTreatmentSystems2019DRAFT.pdf

RULE IMPACT STATEMENT:

Copies of the rule impact statement may be obtained from the contact person or may be reviewed online at https://www.deq.ok.gov/wp-content/uploads/deqmain/resources/641-RIS_Final_19-10-07.pdf

CONTACT PERSON:

The contact person is Nicholas Huber, Environmental Program Manager, ECLS, Department of Environmental Quality. Nicholas may be contacted at: nicholas.huber@deq.ok.gov (e-mail) or (405) 702-6100 (phone). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The DEQ's mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

ADDITIONAL INFORMATION:

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

[OAR Docket #19-798; filed 10-25-19]

TITLE 730. DEPARTMENT OF TRANSPORTATION CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #19-795]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 3. Transportation Commission
730:1-3-6. Election of Director [REVOKED]

SUMMARY:

The proposed rulemaking action is to reflect the changes in state statute and to help bring the Department's Administrative Rules to a current state. Due to the passing of SB 457, the election of the Director is no longer under the Transportation Commission's authority. 61 O.S., § 305 places the authority with the Governor. It is necessary to revoke the rule that is located under Transportation Commission authority so that there is not a conflict with statute.

AUTHORITY:

Oklahoma Transportation Commission; 51 O.S., §24A.1 et seq.; 66 O.S., § 304; 69 O.S., §§ 302, 303, 304, 305, 306, 310, 311, 501, 704, 4002, 4006, and 4007; 74 O.S., §§ 85.58A through 85.58P, 500.6a, and 840-1-1 et seq.

COMMENT PERIOD:

Persons wishing to present their views in writing may do so before 5:00 p.m. on December 16, 2019 at the following address: Tara Moore, Office of the Director, 200 NE 21st Street, Oklahoma City, OK 73105, or tlmoore@odot.org.

PUBLIC HEARING:

A public hearing has not been scheduled; however, pursuant to 75 O.S., §303 (B) (9), "persons may demand a hearing" by contacting Tara Moore at (405) 522-8151 or tlmoore@odot.org no later than 5:00pm on December 16, 2019.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the Department of Transportation, Tara Moore, 200 NE 21st Street, Oklahoma City, OK 73105 or sent electronically by sending request to: tlmoore@odot.org

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement will be prepared and may be obtained from the Oklahoma Department of Transportation at the above address beginning November 18, 2019.

CONTACT PERSON:

Tara Moore, Coordinator of Executive Administration, (405)522-8151

[OAR Docket #19-795; filed 10-24-19]

**TITLE 730. DEPARTMENT OF TRANSPORTATION
CHAPTER 1. ADMINISTRATIVE OPERATIONS**

[OAR Docket #19-796]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Department of Transportation
730:1-5-1. Powers and duties of Director [AMENDED]

SUMMARY:

The proposed amendments would modify the Director's delegation to field division engineers' authority to approve and execute change orders and supplemental agreements in a total amount of not to exceed Seventy Five Thousand Dollars (\$75,000.00) on a contract to One Hundred Fifty Thousand Dollars (\$150,000.00).

AUTHORITY:

Oklahoma Transportation Commission; 51 O.S., §24A.1 et seq.; 66 O.S., § 304; 69 O.S., §§ 302, 303, 304, 305, 306,

310, 311, 501, 704, 4002, 4006, and 4007; 74 O.S., §§ 85.58A through 85.58P, 500.6a, and 840-1-1 et seq.

COMMENT PERIOD:

Persons wishing to present their views in writing may do so before 5:00 p.m. on December 16, 2019 at the following address: Tara Moore, Office of the Director, 200 NE 21st Street, Oklahoma City, OK 73105, or tlmoore@odot.org.

PUBLIC HEARING:

A public hearing will be held at 2:30 p.m. on Monday, December 16, 2019 at the Oklahoma Department of Transportation, 200 NE 21st Street, Oklahoma City, OK 73105. Anyone who wishes to speak must sign in at the door by 2:35pm.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the Department of Transportation, Tara Moore, 200 NE 21st Street, Oklahoma City, OK 73105 or sent electronically by sending request to: tlmoore@odot.org

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement will be prepared and may be obtained from the Oklahoma Department of Transportation at the above address beginning November 18, 2019.

CONTACT PERSON:

Tara Moore, Coordinator of Executive Administration, (405)522-8151

[OAR Docket #19-796; filed 10-24-19]

**TITLE 730. DEPARTMENT OF TRANSPORTATION
CHAPTER 45. PUBLIC TRANSPORTATION PROJECT DEVELOPMENT ASSISTANCE**

[OAR Docket #19-797]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

730:45-1-2. Authority [AMENDED]

SUMMARY:

The proposed amendments would modify and bring up to date the Governor's delegation of the annual appropriations for the Urbanized Area Formula Program by removing the University of Oklahoma and replacing with the City of Norman.

AUTHORITY:

Oklahoma Transportation Commission; 69 O.S., §§ 303, 4002, and 4031 through 4035; P.L 105-178.

COMMENT PERIOD:

Persons wishing to present their views in writing may do so before 5:00 p.m. on December 16, 2019 at the following

Notices of Rulemaking Intent

address: Tara Moore, Office of the Director, 200 NE 21st Street, Oklahoma City, OK 73105, or tlmoore@odot.org.

PUBLIC HEARING:

A public hearing has not been scheduled; however, pursuant to 75 O.S., §303 (B) (9), "persons may demand a hearing" by contacting Tara Moore at (405) 522-8151 or tlmoore@odot.org no later than 5:00pm on December 16, 2019.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Department requests that business entities affected by these proposed rules provide the Department, within the comment period, any costs expected to be incurred due to compliance with the proposed rules. Business entities may submit this information in writing to Tara Moore, at the above address, before the close of the comment period on December 16, 2019.

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the Department of Transportation, Tara Moore, 200 NE 21st Street, Oklahoma City, OK 73105 or sent electronically by sending request to: tlmoore@odot.org

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement will be prepared and may be obtained from the Oklahoma Department of Transportation at the above address beginning November 18, 2019.

CONTACT PERSON:

Tara Moore, Coordinator of Executive Administration, (405)522-8151

[OAR Docket #19-797; filed 10-24-19]

Submissions to Governor and Legislature

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

TITLE 150. OKLAHOMA DEPARTMENT OF COMMERCE CHAPTER 35. ENTERPRISE ZONES

[OAR Docket #19-783]

RULEMAKING ACTION:

Submission to Governor and Legislature

RULES:

Subchapter 9. Incentives

150:35-9-2. Priority enterprise zone incentives [NEW]

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:

October 11, 2019

[OAR Docket #19-783; filed 10-11-19]

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

[OAR Docket #19-792]

RULEMAKING ACTION:

Submission to Governor and Legislature

RULES:

Subchapter 5. Educator Preparation Program Accreditation

218:10-5-3 [AMENDED]

Subchapter 7. Educator Assessment

218:10-7-1 [AMENDED]

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:

October 17, 2019

[OAR Docket #19-792; filed 10-21-19]

Withdrawn Rules

An agency may withdraw proposed PERMANENT rules prior to "final adoption," as defined in 75 O.S., Section 250.3(5), by notifying the Governor and the Legislature, and by publishing a notice of such a withdrawal in the *Register*.

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

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

TITLE 460. DEPARTMENT OF MINES CHAPTER 12. WATER QUALITY STANDARDS IMPLEMENTATION PLAN

[OAR Docket #19-791]

RULEMAKING ACTION:

Withdrawal of EMERGENCY rulemaking

WITHDRAWN RULES:

Appendix B [NEW]

DATES:

Adoption:

September 25, 2019

Submission of adopted rules to Governor and Legislature:

October 7, 2019

Withdrawn:

October 10, 2019

ADDITIONAL INFORMATION:

APPENDIX B, to the new Chapter 12, is in fact OAC 460:30. Chapter 30. Coal Combustion By-Product Standards, was codified on August 26, 2003. A codified chapter of the Oklahoma Administrative Code, cannot be an Appendix to another OAC Chapter, so this APPENDIX B needs to be withdrawn.

[OAR Docket #19-791; filed 10-18-19]

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 165. CORPORATION COMMISSION CHAPTER 35. ELECTRIC UTILITY RULES

[OAR Docket #19-786]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

- Subchapter 45. Wind Energy
- 165:35-45-2. Definitions [AMENDED]
- 165:35-45-4. Notification of intent to build a wind energy facility and other notices [AMENDED]
- 165:35-45-5. Commission consideration [AMENDED]

AUTHORITY:

Corporation Commission; Article IX, Section 18 of the Oklahoma Constitution; 17 O.S. §§ 160.11 *et seq.*

COMMENT PERIOD:

August 6, 2019 through August 20, 2019

PUBLIC HEARING:

August 20, 2019

ADOPTION:

August 20, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

These rules are needed on an emergency basis due to the passage of House Bill 2118, which modified the Oklahoma Wind Energy Development Act. Further, the Commission believes that the proposed changes are necessary to protect the public health, safety and welfare, avoid serious prejudice to the public interest, and to protect national security.

GIST/ANALYSIS:

The purpose of the proposed emergency rules is to address changes to the Oklahoma Wind Energy Development Act, which was amended by House Bill 2118. The proposed changes to OAC 165:35, Subchapter 45 include: removing the definition of "Mitigation plan;" amending the definition of "Project boundary;" general grammatical changes; and modifying the notification of intent to build a wind energy facility section to align with the requirements in HB 2118.

CONTACT PERSON:

Kyle Vazquez, Assistant General Counsel, by telephone 405-522-2100, e-mail kyle.vazquez@occ.ok.gov, or to Jeff W. Kline, Deputy General Counsel, by telephone at (405) 521-2308, e-mail at jeff.kline@occ.ok.gov, or at Room 400, Jim Thorpe Office Building, 2101 North Lincoln Boulevard,

Oklahoma City, Oklahoma 73105, or Post Office Box 52000, Oklahoma City, Oklahoma 73152-2000.

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., § 253(F):

SUBCHAPTER 45. WIND ENERGY

165:35-45-2. Definitions

In addition to terms defined in the Oklahoma Wind Energy Development Act, 17 O.S. § 160.11 *et seq.*, the following word(s) or term(s), when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Clearinghouse" means the Military Aviation and Installation Assurance Siting Clearinghouse.

"Determination of No Hazard" means a document issued by the Federal Aviation Administration.

"FAA" means the Federal Aviation Administration.

"Mitigation plan" means a document issued by the Military Aviation and Installation Assurance Siting Clearinghouse.

"Project description boundary" means a graphic depiction of a wind energy facility's outer boundary, which should adequately demonstrate the project's outer perimeter, inclusive of all wind turbines.

165:35-45-4. Notification of intent to build a wind energy facility and other notices

(a) ~~The Within six (6) months of the initial filing with the FAA, the owner of a wind energy facility shall electronically submit notification of intent to build a facility to the Commission within six (6) months of the initial filing pertaining to commencement of construction with the FAA of an FAA Form 7460-1 (Notice of Proposed Construction or Alteration) or any subsequent form required by the FAA. Such notification shall be submitted to the PUD Director, and shall include any and all Notices of Proposed Construction, or Alteration~~

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required to be filed with the FAA concerning a specific wind energy facility to the PUD Director all initial 7460-1 forms for all individual wind turbines or any other individual structure that requires a FAA Form 7460-1 that is part of a wind energy facility, an attestation of compliance with the provisions of 17 O.S. § 160.20 (A), and a map of the project boundary. Within thirty (30) days of the initial filing with the FAA, the owner of a wind energy facility shall submit copies of all initial 7460-1 forms for individual wind turbines and other individual structures that require a 7460-1 that are part of a wind energy facility to the Aeronautics Commission.

(b) PUD shall provide the owner of a wind energy facility with affirmation of submission of the notification of intent to build by either providing proof of receipt stamp or confirmation of receipt if submission is made electronically.

~~(c) In the event that an owner of a wind energy facility submits notification of intent to build a facility with the Commission and files subsequent forms with the FAA, the owner is not required to submit amended or additional notification of intent to build a wind energy facility unless the project layout is expanded beyond the original project description. Movement within the original description will not require the notice process to start over. However, subsequent to submissions under (a) above, copies of FAA submissions for individual turbine modifications, additional turbines, or renewals shall be submitted to PUD within thirty (30) calendar days of submission to the FAA. If, during or after construction of an individual turbine, the FAA requires the developer to submit subsequent FAA filings, the developer shall submit all such subsequent submissions at the time the wind energy facility's first annual report is submitted.~~

~~(d) The owner of the wind energy facility shall send copies of the notification with the board of county commissioners of every county in which all or a portion of the wind energy facility is to be located within twenty-four (24) hours of submission with the Commission. If all or a portion of the wind energy facility is to be located within the incorporated area of a municipality, copies of the notification shall also be sent to the governing body of the municipality within twenty-four (24) hours of submission with the Commission.~~

~~(e) Within thirty (30) calendar days of submitting the notification, as described above in (a), to the PUD Director, the owner of the wind energy facility shall cause a copy of the notification to be submitted to the Oklahoma Strategic Military Planning Commission. Subsequent 7460-1s required to be filed shall also be submitted to the Oklahoma Strategic Military Planning Commission at the same time as submission to the PUD Director. When the Oklahoma Strategic Military Planning Commission submits its letter to the Clearinghouse, such letter shall be submitted at the same time to the PUD Director and the owner of the wind energy facility.~~

~~(f) Within six (6) months of submitting the notification with the Commission as provided for in subsection (a) of this section, the owner of the wind energy facility shall cause a copy of the notification to be published in a newspaper of general circulation in the county or counties in which all or a portion of the wind energy facility is to be located. Proof of publication shall be submitted to the PUD Director.~~

~~(g) Within sixty (60) calendar days of publishing the notification in a newspaper as provided for in subsection (f) of this section, the owner of the wind energy facility shall hold a public meeting. Notice of the public meeting shall be published in a newspaper of general circulation and submitted to the board of county commissioners in the county or counties in which all or a portion of the wind energy facility is to be located. The notice shall contain the place, date and time of the public meeting. Proof of publication of the notice shall be submitted to the PUD Director. The public meeting shall be held in one of the counties in which all or a portion of the wind energy facility is to be located.~~

~~(f) If the owner of a wind energy facility is required to file subsequent 7460-1 forms with the FAA due to changing locations or heights of individual structures from the locations or heights originally proposed in the initial 7460-1 forms submitted to the Oklahoma Aeronautics Commission, the owner shall, within ten (10) calendar days of filing with the FAA, submit such subsequent 7460-1 forms to the Corporation Commission and Aeronautics Commission. A wind energy facility owner shall not be required to start the notification processes over unless the subsequent 7460-1 forms expand the project beyond its original project boundary submitted to the Corporation Commission.~~

~~(h) The owner of a wind energy facility shall not commence construction on the facility until the notification and public meeting requirements of this section have been met. If an owner of a wind energy facility fails to submit the information as required in this section, the owner shall be subject to an administrative penalty from the Commission not to exceed One Thousand Five Hundred Dollars (\$1,500) per day, per violation following hearing and issuance of a final order of the Commission.~~

~~(i) Subsequent to submitting the notification, as described above in (a), Determinations of No Hazard issued by the FAA, or, approved mitigation plans issued by the Clearinghouse shall be submitted to the PUD Director by the owner of a wind energy facility as follows:~~

~~(1) Within thirty (30) calendar days of receipt of an active Determination of No Hazard issued by the FAA; or~~

~~(2) Within thirty (30) calendar days of receipt of an approved mitigation plan from the Clearinghouse.~~

~~(3) Any Determination of No Hazard or mitigation plan issued prior to the initial submission of the notification described above in (a) shall be submitted to the PUD Director by the owner of a wind energy facility within thirty (30) calendar days of such initial notification submission.~~

~~(h) No individual wind turbine or any other individual structure that requires a FAA 7460-1 form that is part of a wind energy facility may be constructed or expanded unless there is an active Determination of No Hazard from the FAA and adverse impacts to the United States Department of Defense, pursuant to Title 32 of the Code of Federal Regulations, Section 211.6, have been resolved as evidenced by documentation from the Clearinghouse for the individual wind turbine or other individual structure. The Mission Compatibility Certification Letter~~

or successor form may serve as such evidence of adverse impacts being resolved with the Department of Defense or successor agency. Determinations of No Hazard and documentation of the resolution of adverse impacts to the Department of Defense shall be submitted by the owner of a wind energy facility to the Corporation Commission and the Aeronautics Commission.

(i) If an owner of a wind energy facility fails to submit an active Determination of No Hazard and documentation that adverse impacts to the Department of Defense have been resolved by the Clearinghouse for the individual turbine or other individual structure prior to the start of construction, the owner shall be subject to an administrative penalty not to exceed One Thousand Five Hundred Dollars (\$1,500.00) per day, per violation from the Corporation Commission.

(j) All notices, notifications, Determinations of No Hazard, ~~mitigation plans~~, and proof of compliance with all provisions of the Oklahoma Wind Energy Development Act, shall be retained by the wind energy developer, for a period of three (3) years after commercial operation date; and, upon reasonable request, PUD may inspect these documents to ensure compliance.

(k) The owner of a wind energy facility shall electronically provide a notice to the PUD Director indicating that it has commenced the 60-day notice as required by 17 O.S. § 160.21(F). Such notice shall be sent to the PUD Director prior to commencement of construction of the wind energy facility. The notice to the PUD Director shall also include an affirmation that all required notices and notifications have been properly provided, and a list of the recipients of all required notices and notifications shall be retained by the wind energy developer and made available to PUD upon reasonable request.

(l) All submissions shall be submitted electronically to PUD, unless prior approval is granted by the PUD Director.

165:35-45-5. Commission consideration

(a) PUD shall review and may investigate all wind energy facility information reported or submitted for compliance with the annual reporting requirements in this Subchapter or in 17 O.S. § 160.18 or with the notice requirements in this Subchapter or in 17 O.S. § 160.20 or 17 O.S. § 160.21.

(b) After receiving a report or submission from a wind energy facility pursuant to the annual reporting requirements in this Subchapter or in 17 O.S. § 160.18 or the notice requirements in this Subchapter regarding notice of intent to construct ~~or~~ in 17 O.S. § 160.20 or 17 O.S. § 160.21, PUD will:

- (1) Determine whether the report or submission is compliant with the annual reporting or notice requirements; and
- (2) Inform the wind energy facility owner or operator of PUD's determination within thirty (30) calendar days of receipt of the report or submission if it is not in compliance. In the event PUD determines the wind energy facility's report or submission is not in compliance, PUD shall contact the owner or operator to require additional information; and, such information shall be provided within

fifteen (15) calendar days of such notice. If the facility owner fails to correct such non-compliance, PUD may reject the report or submission and may open an investigation to inquire further into the reported or submitted information.

[OAR Docket #19-786; filed 10-15-19]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 1. ADMINISTRATIVE OPERATIONS**

[OAR Docket #19-780]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. Organization and Administration

317:1-1-4 [AMENDED]

317:1-1-6 [AMENDED]

317:1-1-7 [AMENDED]

(Reference APA WF # 19-11)

AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

ADOPTION:

August 21, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, 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 its current policy, in order to avoid violation of State law. The approval of the Board organization emergency rule would allow the Oklahoma Health Care Authority (OHCA) to comply with Senate Bill (SB) 456, which directed the reorganization of the OHCA Board.

GIST/ANALYSIS:

These emergency revisions are necessary to reform the OHCA Board structure in accordance with Senate Bill (SB) 456, which was signed into law on March 13, 2019. Further revisions establish that the chair and vice-chair elections are held on January 1 of each year. Other revisions are needed to correct outdated language.

CONTACT PERSON:

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

SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

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317:1-1-4. Organization and meetings

(a) The Authority Board consists of ~~seven (7)~~nine (9) members. Section 5007 of Title 63 of the Oklahoma Statutes (O.S.) provides for their appointment and service.

(b) A chair and a ~~Vice Chair~~vice-chair shall be elected by a majority of the members of the Board. The terms of office of the ~~Chair and Vice Chair~~chair and vice-chair shall be one (1) year beginning ~~July~~January 1 of each year. A member elected to serve as ~~Chair or Vice Chair~~chair or vice-chair may be elected to serve more than one (1) term. Elections will be held at the last regular meeting before ~~July~~January 1. However, in the event the last regular meeting before ~~July~~January 1 shall be canceled for any reason, the election may be held at a specially-scheduled meeting or, if it is not possible to schedule a special meeting, at the next ~~regularly scheduled~~regularly-scheduled meeting. In the event an election ~~can not~~cannot be conducted prior to ~~July~~January 1 of any year, the ~~Chair and Vice Chair~~chair and vice-chair who are in office ~~June 30~~December 31 shall continue their terms until an election is held.

(c) The chair will preside over meetings and perform other duties as required by the Authority~~{65:5008(A)}~~.

(d) A majority of the members of the Board shall constitute a quorum for the transaction of business and for taking any official action. Any action or decision of the Board requires an affirmative vote of at least a majority of the members present ~~{63:5007(D)}~~{63 O.S. § 5007(D)}.

(e) All meetings of the Authority Board will be conducted in accordance with the Open Meetings~~Meeting~~ Act, ~~Sections 301 through 314~~Sections 301 through 314 of Title 25 of the Oklahoma Statutes~~25 O.S. §§ 301 - 314~~.

317:1-1-6. ~~Cancellation~~Emergency cancellation of meetings

The ~~Chairman~~chair, or the vice-chair in the chair's absence, shall have the power to cancel or reschedule any regular or special meeting of the Authority due to anticipated lack of quorum, inclement weather, or other emergency. Notice ~~of cancellation of said meeting~~thereof shall be ~~posted~~filed with the Secretary of State and publicly posted as soon as reasonably possible~~and in the same manner as the agenda~~.

317:1-1-7. Minutes of the Authority

A summary shall be made of all proceedings before the Authority which shall show those members present and absent, all matters considered, all actions taken, and the vote of each member on any motion, and shall be made public, ~~as prescribed in OAC 317:1-1-10(e)~~on the Authority's website.

[OAR Docket #19-780; filed 10-11-19]

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

[OAR Docket #19-781]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-22.1 [AMENDED]

Part 3. Hospitals

317:30-5-42.11 [AMENDED]

(Reference APA WF # 19-12)

AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

ADOPTION:

August 21, 2019

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Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, 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 its SoonerCare general provider policies in order to protect the public health, safety, or welfare by increasing access to obstetrical services for women.

GIST/ANALYSIS:

These emergency revisions are necessary in order to improve and expand access to obstetrical care in rural Oklahoma areas. The changes to the Enhanced Services for the Medically High Risk Pregnancies policy allow for the addition of the new provider type, Family Practice Physicians - Obstetrics (FP/OB). These providers will be allowed to evaluate and treat a subset of diagnoses presently allowed to board certified/board eligible obstetricians and gynecologists. This rule change will assist in keeping rural providers and hospitals from losing revenue when performing services for high-risk obstetrical services that are usually required to be referred to a Maternal Fetal Medicine specialist for consultation and evaluation. There are approximately fifteen (15) FP/OBs in the state that will be affected by this rule change and would be able to immediately start providing these services upon approval of this rule change.

CONTACT PERSON:

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:

- (1) prenatal at risk antepartum management;
- (2) a combined maximum of five ~~(5)~~ fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses) with one ~~(1)~~ test per week beginning at ~~32~~thirty-two (32) weeks gestation and continuing to ~~38~~thirty-eight (38) weeks; and
- (3) a maximum of three ~~(3)~~ follow-up ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

- (1) ~~ACOGA comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and~~
- (2) ~~appropriate~~Appropriate documentation supporting medical necessity from a ~~Board—Eligible/Board Certified~~board eligible/board certified Maternal Fetal Medicine (MFM) specialist, ~~or a Board—Eligible/Board Certified board eligible/board certified~~Obstetrician-Gynecologist (OB-GYN), or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA Medical Authorizations Unit webpage.

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

- (1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.
- (2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C)] are reimbursed when prior authorized.
- (3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 3. HOSPITALS

317:30-5-42.11. Observation/treatment

(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation services must include a minimum of ~~eight~~ (8) hours of continuous care. Outpatient observation services are not covered when they are provided:

- (1) On the same day as an emergency department visit.
- (2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.
- (3) For the convenience of the member, member's family or provider.
- (4) When specific diagnoses are not present on the claim.
- (5) As part of another service, i.e. for post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy.

(b) Payment is made for observation services in a labor or delivery room. Observation services must include a minimum of eight (8) hours of continuous care. Specific pregnancy-related diagnoses are required. ~~During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.~~

[OAR Docket #19-781; filed 10-11-19]

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

[OAR Docket #19-782]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 83. ~~Residential Behavior Management Services~~Therapeutic Foster Care
- 317:30-5-740 [AMENDED]
- 317:30-5-740.1 [AMENDED]
- 317:30-5-740.2 [AMENDED]
- 317:30-5-741 [AMENDED]
- 317:30-5-742 [AMENDED]
- 317:30-5-742.1 [AMENDED]
- 317:30-5-742.2 [AMENDED]
- 317:30-5-743.1 [AMENDED]
- 317:30-5-744 [AMENDED]
- 317:30-5-745 [AMENDED]
- 317:30-5-746 [AMENDED]
- Part 84. Intensive Treatment Family Care [NEW]
- 317:30-5-750 [NEW]
- 317:30-5-750.1 [NEW]
- 317:30-5-750.2 [NEW]
- 317:30-5-751 [NEW]
- 317:30-5-752 [NEW]
- 317:30-5-753 [NEW]

Emergency Adoptions

317:30-5-754 [NEW]
317:30-5-755 [NEW]
317:30-5-756 [NEW]
317:30-5-757 [NEW]

(Reference APA WF # 19-05)

AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

ADOPTION:

August 21, 2019

EFFECTIVE:

Immediately upon Governor's approval or September 2, 2019, whichever is later.

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, 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 new and amended rules to its Individual Providers and Specialties policy in order to protect the public health, safety, or welfare. The Oklahoma Department of Human Services (DHS) and Office of Juvenile Affairs (OJA) requested the Oklahoma Health Care Authority (OHCA) promulgate new and amended rules, to increase reimbursement of qualified Treatment Parent Specialists (TPS) within the current therapeutic foster care (TFC) model, and to implement an evidence-based intensive treatment family care (ITFC) foster care model. The goal of the ITFC model is to ensure that foster children with severe emotional and behavioral disorders can receive the support services they need in a highly skilled and structured family setting. The approval of the emergency rules would help increase financial support to specially trained foster parents, decrease children's disruptive episodes, and help mitigate lengthy out-of-home residential placements.

GIST/ANALYSIS:

These emergency revisions are necessary in order to increase reimbursement of qualified Treatment Parent Specialists (TPS) within the current therapeutic foster care (TFC) model, and to implement the new intensive treatment family care (ITFC) foster care model.

CONTACT PERSON:

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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 SEPTEMBER 2, 2019, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES THERAPEUTIC FOSTER CARE

317:30-5-740. Eligible providers Definitions

(a) **Definitions.** The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

(1) ~~**Therapeutic foster care (TFC) agencies.** A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.~~

(2) ~~**Therapeutic foster care homes.** Agency supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out of home placement for children with severe emotional disorders.~~

(b) **TFC Agency Requirements.** Eligible TFC agencies must have:

(1) ~~current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency;~~

(2) ~~a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;~~

(3) ~~a contract with the Oklahoma Health Care Authority; and~~

(4) ~~a current accreditation status appropriate to provide behavioral health services in a foster care setting from:~~

(A) ~~The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or~~

(B) ~~the Rehabilitation Accreditation Commission (CARF), or~~

(C) ~~the Council on Accreditation (COA), or~~

(D) ~~the American Osteopathic Association (AOA).~~

"Therapeutic foster care (TFC) agency" means a foster care agency that provides foster care as defined in Public Welfare, 45 Code of Federal Regulation (CFR), Sec. 1355.20 as twenty-four (24) hour substitute care for children and adolescents placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. TFC settings are foster family homes.

"TFC home" means an agency-supervised, private family home in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family-living environment. The children and adolescents receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. TFC homes are considered the least restrictive out-of-home placement for these children or adolescents.

"Therapeutic foster care (TFC) model" means a model in which children and adolescents in the TFC environment receive increased individualized behavioral health and other support services from qualified staff. Because TFC members require exceptional levels of skill, time, and supervision, the number of unrelated children and/or adolescents placed per home is limited; no more than two (2) TFC members may be placed in a home at any one (1) time unless additional cases

are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA).

317:30-5-740.1. Provider qualifications and requirements
Eligible providers and requirements

(a) **Therapeutic foster care model.** Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:

(1) **Certified Behavioral Health Case Manager II (CM).** A bachelors level team member that may provide support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (e), the CM must have:

- (A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families; and
- (B) have access to weekly consultation with a licensed behavioral health professional or Licensure Candidate.
- (C) CM must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation services.

(2) **Licensed Behavioral Health Professional (LBHP).** A masters level professional that provides treatment and supervision for the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or Licensure Candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:

- (A) case management, assessment and treatment planning;
- (B) treatment of victims of physical, emotional, and sexual abuse;
- (C) treatment of children with attachment disorders;
- (D) treatment of children with hyperactivity or attention deficit disorders;
- (E) treatment methodologies for emotionally disturbed children and youth;
- (F) normal childhood development and the effect of abuse and/or neglect on childhood development;
- (G) anger management;
- (H) crisis intervention; and

- (I) trauma informed methodology.
- (3) **Licensed Psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.

(4) **Treatment Parent Specialist (TPS).** The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:

- (A) have a high school diploma or equivalent;
- (B) have an employment relationship with the foster care agency as a foster parent complete with OSBI and OKDHS background screening;
- (C) completion of therapeutic foster parent training outlined in this section;
- (D) have a minimum of twice monthly face to face supervision with the licensed, or under supervision for licensure, LBHP, independent of the child's family therapy;
- (E) have weekly contact with the foster care agency professional staff; and
- (F) complete required annual trainings.

(e) **Agency assurances.** The TFC agency must ensure that each individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority.

(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

- (1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;
- (2) treatment of victims of physical, emotional, and sexual abuse;
- (3) treatment of children with attachment disorders;
- (4) treatment of children with hyperactive or attention deficit disorders;
- (5) normal childhood development and the effect of abuse and/or neglect on childhood development;
- (6) treatment of children and families with substance use disorders;
- (7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
- (8) anger management;

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- (9) inpatient authorization procedures;
 - (10) crisis intervention;
 - (11) grief and loss issues for children in foster care;
 - (12) the significance/value of birth families to children receiving behavioral health services in a foster care setting; and
 - (13) trauma-informed methodology.
- (a) **TFC agency.** Eligible TFC agencies must have:
- (1) Current certification from the Oklahoma Department of Human Services (DHS) as a child placing agency;
 - (2) A contract with the Child Welfare Division of DHS, or Oklahoma Office of Juvenile Affairs (OJA);
 - (3) A contract with the Oklahoma Health Care Authority (OHCA); and
 - (4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:
 - (A) The Joint Commission; or
 - (B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or
 - (C) The Council on Accreditation (COA).
- (b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of a DHS or OJA caseworker, the member, the member's foster parent(s), as well as others closely involved with the member and family, including the biological parents when applicable. It also includes the following:
- (1) **Certified behavioral health case manager (CM II).** A bachelor's level team member that may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:
 - (A) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children/adolescents and/or families; and
 - (B) Have access to weekly consultation with a licensed behavioral health professional (LBHP) or licensure candidate.
 - (C) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.
 - (2) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.
 - (3) **Licensed behavioral health professional (LBHP) and/or licensure candidate.** An LBHP is a master's level professional that provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. A licensure candidate is a practitioner actively and regularly receiving board-approved supervision, or extended supervision by a fully-licensed clinician if the board's supervision requirement is met but the individual is not yet licensed. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or licensure candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:
 - (A) Case management, assessment, and treatment planning;
 - (B) Treatment of victims of physical, emotional, and sexual abuse;
 - (C) Treatment of children/adolescents with attachment disorders;
 - (D) Treatment of children/adolescents with hyperactivity or attention deficit disorders;
 - (E) Treatment methodologies for emotionally disturbed children/adolescents;
 - (F) Normal childhood development and the effect of abuse and/or neglect on childhood development;
 - (G) Anger management;
 - (H) Crisis intervention; and
 - (I) Trauma-informed methodology.
- (4) **Licensed psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.
- (5) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the member. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP or licensure candidate of the foster care agency and meet the following criteria:
- (A) **Qualifications.**
 - (i) Have a high school diploma or equivalent;
 - (ii) Have an employment and/or contractual relationship with the foster care agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and DHS background screenings;
 - (iii) Complete the initial thirty-six (36) hours of pre-service training, prior to becoming a TFC parent;
 - (B) **Responsibilities.**
 - (i) Have a minimum of twice monthly face-to-face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the member's family therapy;
 - (ii) Have weekly contact with the foster care agency professional staff;
 - (iii) Complete the required eighteen (18) hours of in-service training per calendar year; and

(iv) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(c) **Agency assurances.** The TFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and, if eligible for direct enrollment, is fully contracted with the OHCA. Additionally, the TFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (CFR), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible TFC agency providers shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

- (1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children/adolescents;
- (2) Treatment of victims of physical, emotional, and sexual abuse;
- (3) Treatment of children/adolescents with attachment disorders;
- (4) Treatment of children/adolescents with hyperactive or attention deficit disorders;
- (5) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (6) Treatment of children/adolescents and families with substance use disorders;
- (7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
- (8) Anger management;
- (9) Inpatient authorization procedures;
- (10) Crisis intervention;
- (11) Grief and loss issues for children/adolescents in foster care;
- (12) The significance/value of birth families to children/adolescents receiving behavioral health services in a foster care setting; and
- (13) Trauma-informed methodology.

317:30-5-740.2. Provider selection

Parents who retain legal custody of a client may select any eligible contractor as the provider of services. In the case of children in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the provider agency. Parents who retain legal custody of a TFC child or adolescent may select any eligible TFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the TFC agency.

317:30-5-741. Coverage by category

- (a) **Adults.** Behavioral health services in therapeutic foster care settings are not covered for adults.
- (b) **Children.** Behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving services in this setting have special psychological, social and

emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting.

(e) **Medical necessity criteria.** Medical necessity criteria is delineated as follows:

- (1) A diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b) within the 30 day period resulting in a diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.
- (2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.
- (3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.
- (4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.
- (5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.
- (6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

(a) **Adults.** Behavioral health services in TFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in TFC settings for children and adolescents as medically necessary. The children and adolescents receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. The designated children and adolescents must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in a TFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) **Medical necessity criteria.** In order to satisfy medical necessity criteria, all of the following conditions must be met:

- (1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders

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(DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children and adolescents with a provisional diagnosis may receive TFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) or licensure candidate as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) and (b) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in a TFC setting.

(3) Conditions are directly attributed to moderate behavioral and emotional needs as the primary need for professional attention.

(4) It has been determined by an LBHP that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and clinical interventions from professional staff, preventing the member from living in a traditional family home.

(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(7) The legal guardian [Oklahoma Department of Human Services (DHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

317:30-5-742. Description of services

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1)–(6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:

- (1) Individual, family and group therapy;
- (2) Substance abuse/chemical dependency education, prevention, and therapy;
- (3) Psychosocial rehabilitation and support services;
- (4) Behavior management
- (5) Crisis intervention; and
- (6) Case Management.

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The TFC setting is restorative in nature, allowing children and adolescents

with moderate behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-742.2.

(c) Treatment services in a TFC setting must receive at least one (1) hour of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-742.2(3). Treatment may also include, but is not limited to, an array of the following services:

- (1) Individual, family and group therapy;
- (2) Substance abuse/chemical dependency education, prevention, and therapy;
- (3) Psychosocial rehabilitation and support services;
- (4) Behavior management;
- (5) Crisis intervention; and
- (6) Case management.

317:30-5-742.1. Reimbursement

Services provided to a member without a written individual plan of care as described in OAC 317:30-5-742.2(b)(1) will not be reimbursed.

(a) TFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-742.2 will not be reimbursed.

(b) Reimbursement for TFC services is not available for the following:

- (1) Room and board;
- (2) Educational costs;
- (3) Supported employment;
- (4) Inpatient psychiatric services; and
- (5) Respite care.

(c) Case management services are reimbursed to government providers as per the methodology in the approved Oklahoma Medicaid State Plan.

317:30-5-742.2. Individual plan of care (IPC) and prior authorization of services

(a) All behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority (OHCA) before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized. Requests for behavioral health services in a foster care setting may be approved for a maximum of three (3) months per extension request.

(b) All behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.

(1) Assessment.

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face to face contact with the

person and/or the person's family or other persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

~~(B) **Qualified professional.** This service is performed by an LBHP or Licensure Candidate.~~

~~(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from the therapeutic foster care agency. This service is not compensable if the member has previously received or is currently receiving services from the agency unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.~~

~~(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of eighteen (18), it is performed with the direct, active face to face participation of the child and parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include all related diagnoses from the most recent DSM edition. The assessment must contain but is not limited to the following:~~

- ~~(i) Date, to include month, day and year of the assessment session(s);~~
- ~~(ii) Source of information;~~
- ~~(iii) Member's first name, middle initial and last name;~~
- ~~(iv) Gender;~~
- ~~(v) Birth date;~~
- ~~(vi) Home address;~~
- ~~(vii) Telephone number;~~
- ~~(viii) Referral source;~~
- ~~(ix) Reason for referral;~~
- ~~(x) Person to be notified in case of emergency;~~
- ~~(xi) Presenting reason for seeking services;~~
- ~~(xii) Start and stop time for each unit billed;~~
- ~~(xiii) Dated signature of parent or guardian participating in the face to face assessment. Signatures are required for members over the age of fourteen (14);~~
- ~~(xiv) Bio Psychosocial information which must include:

 - ~~(I) Identification of the member's strengths, needs, abilities and preferences;~~
 - ~~(II) History of the presenting problem;~~
 - ~~(III) Previous psychiatric treatment history, include treatment for psychiatric, substance use; drug and alcohol addiction; and other addictions;~~
 - ~~(IV) Health history and current biomedical conditions and complications;~~
 - ~~(V) Alcohol, drug, and/or other addictions history;~~~~

~~(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services (DHS) involvement;~~

~~(VII) Family and social history including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;~~

~~(VIII) Educational attainment, difficulties and history;~~

~~(IX) Cultural and religious orientation;~~

~~(X) Vocational, occupational and military history;~~

~~(XI) Sexual history, including HIV, AIDS, and STD at risk behaviors;~~

~~(XII) Marital or significant other relationship history;~~

~~(XIII) Recreation and leisure history;~~

~~(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers);~~

~~(XV) Present living arrangements;~~

~~(XVI) Economic resources; and~~

~~(XVII) Current support system, including peer and other recovery supports.~~

~~(xv) Mental status and Level of Functioning information, including questions regarding but not limited to the following:~~

~~(I) Physical presentation, such as general appearance, motor activity, attention and alertness;~~

~~(II) Affective process, such as mood, affect, manner and attitude;~~

~~(III) Cognitive process, such as intellectual ability, social adaptive behavior, thought processes, thought content, and memory; and~~

~~(IV) All related diagnoses from the most recent addition of the DSM.~~

~~(xvi) Pharmaceutical information to include the following for both current and past medications;~~

~~(I) Name of medication;~~

~~(II) Strength and dosage of medication;~~

~~(III) Length of time on the medication; and~~

~~(IV) Benefit(s) and side effects of medication.~~

~~(xvii) LBHP's interpretation of findings and diagnosis;~~

~~(xviii) Dated signature and credentials of the qualified practitioner who performed the face to face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional who is responsible for the member's care.~~

(2) Individual plan of care requirement.

(A) Signature Requirement. A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within thirty (30) days of admission

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with documented input from the member, legal guardian (OKDHS/Office of Juvenile Affairs (OJA) staff), the foster parent (when applicable) and the treatment provider(s). An individual plan of care is not valid until all dated signatures are present, including signatures from the member (if fourteen (14) or over), the legal guardian, the foster parent (when applicable) and the treatment provider(s). If necessary, an individual plan of care may be faxed to a required signatory to have them review, sign and fax it back to the provider before its implementation; however, the provider must obtain the original signature for the clinical file within thirty (30) days. No stamped or photocopied signatures are allowed. This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and resident.

(B) Individualization. The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable objectives and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the child's treatment needs and frequency over a given period of time.

(C) Qualified professional. This service is performed by an LBHP or Licensure Candidate.

(D) Time requirements. Individual plan of care updates must be conducted face to face and are required every three (3) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.

(E) Documentation requirements. Comprehensive and integrated service plan content must address the following:

- (i) member strengths, needs, abilities, and preferences (SNAP);
- (ii) identified presenting challenges, problems, needs and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, attainable, realistic, and time limited;
- (v) each type of service and estimated frequency to be received;
- (vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
- (vii) any needed referrals for service;
- (viii) specific discharge criteria; and

(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(F) Amendments. Amendment of an existing individual plan of care to revise or add goals, objectives, service provider, service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing individual plan of care through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member (if fourteen (14) or over), the legal guardian, the foster parent (if applicable), as well as the primary LBHP and any new provider(s). Individual plan of care updates must address the following:

- (i) update to the bio-psycho-social assessment, re-evaluation of diagnosis, individual plan of care goals and/or objectives;
- (ii) progress, or lack of, on previous individual plan of care goals and/or objectives;
- (iii) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;
- (iv) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
- (v) change in frequency and/or type of services provided;
- (vi) change in practitioner(s) who will be responsible for providing services on the plan;
- (vii) change in discharge criteria;
- (viii) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(3) Description of Services. Agency services include:

(A) Individual, family and group therapy. See OAC 317:30-5-241.2(a), (b), and (c).

(B) Crisis/behavior management and redirection. The provider agency must provide crisis/behavior redirection by agency staff as needed twenty four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) Discharge planning. The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow up care and outlines plans that are in place at the time

of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the OKDHS or the OJA must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

(D) Substance use/chemical dependency use therapy. Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, addiction or nicotine use and addiction. This service is to be provided to the member by an LBHP or Licensure Candidate.

(E) Substance Use Rehabilitation Services. Covered substance use rehabilitation services are provided in non residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug use, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training. This service is to be provided to the member by a CM II.

(F) Psychosocial rehabilitation (PSR).

(i) Definition. PSR services are face to face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.

(ii) Clinical Restrictions. This service is generally performed with only the members and the qualified provider, but may include a member and

the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(iii) Qualified Practitioners. CM II, LBHP or a Licensure Candidate and LBHP may perform PSR, following development of an individual plan of care curriculum approved by an LBHP or Licensure Candidate. PSR staff must be appropriately and currently trained in a recognized behavioral/management intervention program such as MANDT or Controlling Aggressive Patient Environment (CAPE) or trauma informed methodology. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face to face consultation with an LBHP is required.

(iv) Group Sizes. The maximum staffing ratio is eight (8) to one (1) for children under the age of eighteen (18).

(v) Limitations.

(I) In order to develop and improve the member's community and interpersonal functioning and self care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age six (6), unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity, are not eligible for PSR services.

(III) PSR services are time limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation

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diminishing return by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health individual plan of care developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress, or barriers made towards goals, objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider;

(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.

(viii) **Non-Covered Services.** The following services are not considered PSR and are not reimbursable:

(I) room and board;

(II) educational costs;

(III) supported employment; and

(IV) respite.

(G) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment

Parent Specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.

All behavioral health services in a TFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All TFC agencies must assess each individual to determine whether he or she could be an appropriate candidate for TFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from the TFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the DSM-V. The assessment must contain, but is not limited to, the following:

(i) Date, to include month, day, and year of the assessment session(s);

(ii) Source of information;

(iii) Member's first name, middle initial, and last name;

(iv) Gender;

(v) Birth date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;

(xii) Start and stop time for each unit billed;

(xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (DHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological

parents(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over; (xiv) Bio-psychosocial information which must include:

- (I) Identification of the member's strengths, needs, abilities, and preferences;
 - (II) History of the presenting problem;
 - (III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;
 - (IV) Health history and current biomedical conditions and complications;
 - (V) Alcohol, drug, and/or other addictions history;
 - (VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including DHS involvement;
 - (VII) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
 - (VIII) Educational attainment, difficulties, and history;
 - (IX) Cultural and religious orientation;
 - (X) Vocational, occupational, and military history;
 - (XI) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
 - (XII) Marital or significant other relationship history;
 - (XIII) Recreation and leisure history;
 - (XIV) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
 - (XV) Present living arrangements;
 - (XVI) Economic resources; and
 - (XVII) Current support system, including peer and other recovery supports.
- (xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:
- (I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
 - (II) Affective process, such as mood, affect, manner, and attitude;
 - (III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
 - (IV) All related diagnoses from the DSM-V.
- (xvi) Pharmaceutical information for both current and past medications, to include the following:

- (I) Name of medication;
- (II) Strength and dosage of medication;
- (III) Length of time on the medication; and
- (IV) Benefit(s) and side effects of medication.

- (xvii) LBHP's interpretation of findings and diagnosis; and
- (xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care.

(2) **IPC requirements.**

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the TFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (DHS/ OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider (s). This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and member.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the TFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP or licensure candidate.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by the qualified practitioner and member.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must identify:

- (i) Member strengths, needs, abilities, and preferences (SNAP);
- (ii) Identified presenting challenges, problems, needs, and diagnosis;
- (iii) Specific goals for the member;

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(iv) Objectives that are specific, attainable, realistic, and time-limited;

(v) Each type of service and estimated frequency to be received;

(vi) The name and credentials of all the practitioners who will be providing and responsible for each service;

(vii) Any needed referrals for service;

(viii) Specific discharge criteria; and

(ix) Member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over].

(F) **Amendments.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:

(i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;

(ii) Progress, or lack of, on previous IPC goals and/or objectives;

(iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of the identified problem behavior that led to TFC placement must be included;

(iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;

(v) Change in frequency and/or type of services provided;

(vi) Change in practitioner(s) who will be responsible for providing services on the plan;

(vii) Change in discharge criteria; and

(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over].

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy.** See Oklahoma Administrative Code (OAC) 317:30-5-241.2(a), (b), and (c). A member must receive one (1) hour of individual, family, and/or group therapy each week that is provided by an LBHP or licensure candidate, and may receive up to two (2) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability

to respond to the residential foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP or a licensure candidate. The licensure candidate must have immediate access to an LBHP who can provide oversight of the licensure candidate and conduct an emergency detention evaluation.

(C) **Discharge planning.** The TFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of DHS or OJA must be developed in collaboration with the case worker and finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from TFC placement into a less restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the DHS and an LBHP within the TFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is to be provided to the member by an LBHP or licensure candidate.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education

and skills training. This service is to be provided to the member by a certified behavioral health case manager (CM) II, certified alcohol drug counselor (CADC) or LBHP.

(F) Psychosocial rehabilitation (PSR).

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education, and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations and/or substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP or licensure candidate.

(iii) **Qualified practitioners.** A CM II, an LBHP, or a licensure candidate may perform PSR, following development of an IPC curriculum approved by an LBHP or licensure candidate. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) practitioner for members under the age of twenty-one (21).

(v) Limitations.

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children/adolescents with Serious Emotional Disturbance (SED), and children/adolescents with moderate behavioral and emotional health

needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP or licensure candidate must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the moderate behavioral and emotional health conditions, and any other secondary physical, developmental, intellectual, and/or social disorder and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress, towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.** Documentation of ongoing consultation

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and/or collaboration with an LBHP or licensure candidate related to the provision of PSR services. (G) Therapeutic behavioral services (TBS). Goal directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.

317:30-5-743.1. Service Quality Reviewquality review (SOR)

~~There will be an on-site Service Quality Review (SOR)SQR performed by the OHCAOklahoma Health Care Authority (OHCA) or its designated agent of each Therapeutic Foster Care (TFC)TFC agency that provides care to members. The OHCA will designate the members of the SQR Teamteam. This team will consist of at least two (2) team members and will be comprised of Licensed Behavioral Health Professionals and/or Registered Nurseslicensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for TFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the on-site inspectionreview, the SQR Teamteam will report its findings to the TFC agency. The TFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the TFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the time lines Timelines designated at OACOklahoma Administrative Code (OAC) 317:30-5-742.2. If the individual plan of careIPC is missing, or it is found that the childmember did not meet medical necessity criteria at any time, all paid services will be recouped for each day the individual plan of careIPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.~~

317:30-5-744. Billing

(a) Claims must be submitted in accordance with guidelines found at OACOklahoma Administrative Code (OAC) 317:30-3-11 and 317:30-3-11.1, and 317:30-3-20.

(b) Claims for dually eligible individuals (Medicare/Medic-aid) should be filed directly with the OHCAOklahoma Health Care Authority (OHCA).

317:30-5-745. Documentation of records

~~All services must be reflected by documentation in the records including the date the service was provided, the beginning and ending time the service was provided, the location in which the service was provided, a description of the resident's response to the service and whether the service provided was an individual, group or family session, group rehabilitative treatment, social skills (re)development, basic living skills (re)development, crisis behavior management and redirection, or discharge planning, and the dated signature with credentials of the person providing the service.~~

~~Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:~~

- ~~(1) The date the service was provided;~~
- ~~(2) The beginning and ending time the service was provided;~~
- ~~(3) A description of the member's response to the service;~~
- ~~(4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and~~
- ~~(5) The dated signature with credentials of the person providing the service.~~

317:30-5-746. Appeal of Prior Authorization DecisionPrior authorization and appeal of prior authorization decision

~~If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the Oklahoma Health Care Authority within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.~~

~~(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.~~

~~(b) If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.~~

PART 84. INTENSIVE TREATMENT FAMILY CARE

317:30-5-750. Definitions

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

"Intensive treatment family care (ITFC) agency" means an agency that provides foster care as defined in Public Welfare, 45 Code of Federal Regulation (CFR), Sec. 1355.20 as twenty-four (24) hour substitute care for children and adolescents placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. ITFC settings are foster family homes.

"Intensive treatment family care (ITFC) home" means an agency-supervised, private family home in which foster parents [at least one (1) parent must be a stay-at home foster] have been trained to provide individualized, structured services in a safe, nurturing family-living environment. These services are provided to children and adolescents with severe behavioral and emotional health needs. They may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs of the member. These members require a higher level of care that cannot be provided in the traditional foster care or TFC home. ITFC homes provide the higher level of care needed for these children and adolescents, and help prevent placement in a more restrictive setting, including an inpatient setting.

"Intensive treatment family care (ITFC) model" means a model in which children and adolescents in the ITFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because ITFC members require exceptional levels of skill, time, and supervision, the number of unrelated children and adolescents placed per home is limited; no more than one (1) ITFC member may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA).

317:30-5-750.1. Eligible providers and requirements

(a) **ITFC agency.** Eligible ITFC agencies must have:

- (1) Current certification from the Oklahoma Department of Human Services (DHS) as a child placing agency;
- (2) A contract with the Child Welfare Division of DHS, or Oklahoma Office of Juvenile Affairs (OJA);
- (3) A contract with the Oklahoma Health Care Authority (OHCA); and
- (4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:
 - (A) The Joint Commission; or
 - (B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or
 - (C) The Council on Accreditation (COA).

(b) **Treatment team.** ITFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of a DHS or OJA caseworker, the member, the member's foster parent(s),

as well as others closely involved with the member and family, including the biological parents when applicable. It also includes the following:

(1) **Certified behavioral health case manager (CM)**

II. A bachelor's level team member who may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

- (A) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children/adolescents and/or families; and
- (B) Have access to weekly consultation with a licensed behavioral health professional (LBHP).
- (C) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(2) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(3) **Licensed behavioral health professional (LBHP).** A master's level professional who provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in an ITFC setting must demonstrate a general professional or educational background in the following areas:

- (A) Case management, assessment, and treatment planning;
- (B) Treatment of victims of physical, emotional, and sexual abuse;
- (C) Treatment of children/adolescents with attachment disorders;
- (D) Treatment of children/adolescents with hyperactivity or attention deficit disorders;
- (E) Treatment methodologies for emotionally disturbed children/adolescents;
- (F) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (G) Anger management;
- (H) Crisis intervention; and
- (I) Trauma-informed methodology.

(4) **Licensed psychiatrist and/or psychologist.** ITFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.

(5) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the children and adolescents. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes

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daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP of the ITFC agency and meet the following criteria:

(A) Qualifications.

- (i) Have a high school diploma or equivalent, and either some post-secondary education and/or a combination of at least two (2) years of personal/professional experience working with children/adolescents with significant needs;
- (ii) Have an employment and/or contractual relationship with the ITFC agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and DHS background screenings;
- (iii) Completed all evidence-informed ITFC foster parent training, as outlined in this section;
- (iv) Complete a minimum of twenty (20) hours of required annual continuing education trainings. Six (6) hours of the twenty (20) training hours must be clinical in nature;
- (v) Agree to have at least one (1) parent in the ITFC home serve as a full-time, stay-at-home parent in order to sufficiently meet the significant needs of the member placed in the ITFC home; and

(B) Responsibilities.

- (i) Have a minimum of twice monthly face-to-face supervision with the LBHP, independent of the member's family therapy;
- (ii) Have weekly contact with the ITFC agency professional staff;
- (iii) Utilize individualized curriculum-based education and support materials with the member to support the member's skill development outside of the clinical setting;
- (iv) Agree, by contract with the ITFC agency, to serve the member in his or her ITFC home through completion of the treatment designated on his or her individual plan of care, and without disruption to the service array; and
- (v) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(c) Agency assurances. The ITFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and is fully contracted with the OHCA. Additionally, the ITFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (CFR), and the Oklahoma State Medicaid Plan.

(d) Policies and procedures. Eligible ITFC agencies shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

- (1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children/adolescents;
- (2) Treatment of victims of physical, emotional, and sexual abuse;
- (3) Treatment of children/adolescents with attachment disorders;
- (4) Treatment of children/adolescents with hyperactive or attention deficit disorders;
- (5) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (6) Treatment of children/adolescents and families with substance use disorders;
- (7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
- (8) Anger management;
- (9) Inpatient authorization procedures;
- (10) Crisis intervention;
- (11) Grief and loss issues for children/adolescents in foster care;
- (12) The significance/value of birth families to children/adolescents receiving behavioral health services in a foster care setting; and
- (13) Trauma-informed methodology.

317:30-5-750.2. Provider selection

Parents who retain legal custody of an ITFC member may select any eligible ITFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the ITFC agency.

317:30-5-751. Coverage by category

(a) Adults. Behavioral health services in ITFC settings are not covered for adults.

(b) Children. Behavioral health services are allowed in ITFC settings for children and adolescents as medically necessary. The children and adolescents receiving services in this setting have severe behavioral and emotional health needs and may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. ITFC homes provide the higher level of care needed for these children or adolescents and help prevent placement in an inpatient or more restrictive setting. The designated children and adolescents must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in an ITFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) Medical necessity criteria. In order to satisfy medical necessity criteria, all of the following conditions must be met:

- (1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children and adolescents with a provisional diagnosis may receive ITFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in an ITFC setting.

(3) Conditions are directly attributed to a primary medical diagnosis of a severe behavioral and emotional health need, and may also be attributed to a secondary medical diagnosis of a physical, developmental, intellectual and/or social disorder that is supported alongside the mental health needs.

(4) It has been determined by an LBHP that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the member from living in a traditional or therapeutic foster home.

(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(7) The legal guardian [Oklahoma Department of Human Services (DHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

317:30-5-752. Description of services

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The ITFC setting is restorative in nature, allowing children and adolescents with severe behavioral and emotional health needs, who may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs, to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-753.

(c) Treatment services in an ITFC must include at least two (2) hours of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-753(3). Treatment may also include, but is not limited to, an array of the following services:

- (1) Substance abuse/chemical dependency education, prevention, and therapy;
- (2) Psychosocial rehabilitation and support services;
- (3) Behavior management;
- (4) Crisis intervention; and
- (5) Case management.

317:30-5-753. Individual plan of care (IPC) requirements

All behavioral health services in an ITFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psychosocial information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All ITFC agencies must assess each individual to determine whether they could be an appropriate candidate for ITFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP).

(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from the ITFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the Oklahoma Health Care Authority (OHCA). In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The assessment must contain, but is not limited to, the following:

- (i) Date, including month, day, and year of the assessment session(s);
- (ii) Source of information;
- (iii) Member's first name, middle initial, and last name;
- (iv) Gender;
- (v) Birth date;
- (vi) Home address;
- (vii) Telephone number;
- (viii) Referral source;
- (ix) Reason for referral;
- (x) Person to be notified in case of emergency;
- (xi) Presenting reason for seeking services;
- (xii) Start and stop time for each unit billed;

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(xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (DHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parent(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;
(xiv) Bio-psychosocial information, which must include:

- (I) Identification of the member's strengths, needs, abilities, and preferences;
- (II) History of the presenting problem;
- (III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;
- (IV) Health history and current biomedical conditions and complications;
- (V) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including DHS involvement;
- (VI) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
- (VII) Educational attainment, difficulties, and history;
- (VIII) Cultural and religious orientation;
- (IX) Vocational, occupational, and military history;
- (X) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
- (XI) Marital or significant other relationship history;
- (XII) Recreation and leisure history;
- (XIII) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
- (XIV) Present living arrangements;
- (XV) Economic resources; and
- (XVI) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:

- (I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
- (II) Affective process, such as mood, affect, manner, and attitude;
- (III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
- (IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following:

- (I) Name of medication;
- (II) Strength and dosage of medication;
- (III) Length of time on the medication; and
- (IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the LBHP who performed the face-to-face behavioral assessment.

(2) **IPC requirements.**

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the ITFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (DHS/OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider(s). This plan must be reviewed every thirty (30) days with documented involvement of the legal guardian and member. The review includes an evaluation of the member's progress in the treatment setting, as well as in other environments, such as home, school, social engagements, etc.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the ITFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by an LBHP. Updates should reflect changes to treatment based on the members' progress or lack thereof.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

- (i) Member strengths, needs, abilities, and preferences (SNAP);

- (ii) Identified presenting challenges, problems, needs and diagnosis;
 - (iii) Specific goals for the member;
 - (iv) Objectives that are specific, attainable, realistic, and time-limited;
 - (v) Each type of service and estimated frequency to be received;
 - (vi) The name and credentials of all the practitioners who will be providing and responsible for each service;
 - (vii) Any needed referrals for service;
 - (viii) Specific discharge criteria; and
 - (ix) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].
- (F) **Amendments.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency must be documented in the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:
- (i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/or objectives;
 - (ii) Progress, or lack of, on previous IPC goals and/or objectives;
 - (iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of identified problem behaviors that led to ITFC placement must be included;
 - (iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;
 - (v) Change in frequency and/or type of services provided;
 - (vi) Change in practitioner(s) who will be responsible for providing services on the plan;
 - (vii) Change in discharge criteria; and
 - (viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].
- (3) **Description of services.** Agency services include:
- (A) **Individual, family, and/or group therapy.** See OAC 317:30-5-241.2(a), (b), and (c). The number of units of individual, family, and/or group therapy within the ITFC setting differ from the number of units available in the outpatient setting. A member must receive two (2) hours of individual,

family, and/or group therapy each week that is provided by an LBHP, and may receive up to three (3) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by ITFC agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff is available to respond to the ITFC foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The ITFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after-care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of DHS or OJA must be developed in collaboration with the case worker and be finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from ITFC placement into a lesser restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS) and an LBHP within the ITFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is provided to the member by an LBHP.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug

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use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is provided to the member by a certified behavioral health case manager (CM) II, a certified alcohol drug counselor (CADC), or an LBHP.

(F) Psychosocial rehabilitation (PSR).

(i) Definition. PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training.

(ii) Clinical restrictions. This service is generally performed with only the member and the qualified provider, but may also include the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery-based curriculum. A member who, at the time of service, is not able to benefit from the treatment due to active hallucinations and/or substance use, or other impairment, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP.

(iii) Qualified practitioners. A CM II or an LBHP may perform PSR, following development of an IPC curriculum. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) Group sizes. The maximum staffing ratio is eight (8) members to one (1) service provider for members under the age of twenty-one (21).

(v) Limitations.

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children/adolescents with Serious Emotional Disturbance (SED), and children/adolescents

with severe behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent, based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) Progress notes. In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the physical, developmental, emotional, and/or social disorders and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) Additional documentation requirements. Documentation of ongoing consultation and/or collaboration with an LBHP related to the provision of PSR services.

(G) **Therapeutic behavioral services (TBS).** Goal-directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and a half (1.5) hours daily.

317:30-5-754. Service quality review (SQR)

(a) Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:

- (1) The date the service was provided;
- (2) The beginning and ending time the service was provided;
- (3) A description of the member's response to the service;
- (4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and
- (5) The dated signature with credentials of the person providing the service.

(b) There will be an SQR review performed by the Oklahoma Health Care Authority (OHCA) or its designated agent of each ITFC agency that provides care to members. The OHCA will designate the members of the SQR team. This team will consist of at least two (2) team members and will be comprised of licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for ITFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the review, the SQR team will report its findings to the ITFC agency. The ITFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the ITFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the timelines designated at Oklahoma Administrative Code (OAC) 317:30-5-753. If the IPC is missing, or it is found that the member did not meet medical necessity criteria at any time, all paid services will be recouped for each

day the IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

317:30-5-755. Billing

(a) Claims must be submitted in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1 and 317:30-3-20.

(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the Oklahoma Health Care Authority (OHCA).

317:30-5-756. Reimbursement

(a) ITFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-753 will not be reimbursed.

(b) In the case of a member who needs additional specialized behavioral health services, prior authorization by the Oklahoma Health Care Authority (OHCA) is required. See OAC 317:30-3-31. Only specialized rehabilitation or psychological treatment services to address unique, unusual, or severe symptoms or disorders will be authorized. Documentation must be provided to ensure that services are not duplicative.

(c) If additional services are approved for a member in state custody, the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA) will collaborate with the provider of such services as directed by the OHCA. Any additional specialized behavioral health services provided to members in state custody are funded in the normal manner.

(d) Reimbursement for ITFC services is not available for the following:

- (1) Room and board;
- (2) Educational costs;
- (3) Supported employment;
- (4) Inpatient psychiatric services; and
- (5) Respite care.

(e) Case management services are reimbursed to government providers as per the methodology in the approved Medicaid State Plan.

317:30-5-757. Prior authorization and appeal of prior authorization decision

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

[OAR Docket #19-782; filed 10-11-19]

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

[OAR Docket #19-793]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Non-Financial Eligibility Criteria
Part 3. Special Households
340:50-5-29 [AMENDED]
Part 5. Students, Strikers, Resident Farm Laborers, Migrant Households, Sponsored Aliens, and School Employees
340:50-5-45 [AMENDED]
Part 10. Able-Bodied Adults without Dependents
340:50-5-101 [AMENDED]
Subchapter 7. Financial Eligibility Criteria
Part 1. Resources
340:50-7-1 [AMENDED]
Part 3. Income
340:50-7-29 [AMENDED]
340:50-7-31 [AMENDED]
Subchapter 9. Eligibility and Benefit Determination Procedures
340:50-9-5 [AMENDED]
(Reference WF 19-03)

AUTHORITY:

Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes; Sections 272.17, 273.5, 273.9, 273.11 and 273.12 of Title 7 of the Code of Federal Regulations (C.F.R.); 7 U.S.C. § 2014, Informational Memos Regarding Section 4009 of the Agricultural Act of 2014 and Sections 4004 and 4005 of the Agriculture Improvement Act of 2018

ADOPTION:

August 26, 2019

APPROVED BY GOVERNOR:

October 2, 2019

EFFECTIVE:

Immediately upon Governor's approval or September 17, 2019, whichever is later

EXPIRATION:

Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

Emergency rulemaking approval is requested to comply with recently issued federal regulation changes. If the proposed revisions are not implemented, DHS will be out of compliance with recent federal regulation changes which may lead to increased federal errors.

GIST/ANALYSIS:

The proposed amendment to update shelter deduction information to allow for a new standard homeless shelter deduction or an excess shelter deduction for homeless households with shelter expenses is submitted as emergency rules to comply with a United States Department of Agriculture (USDA) informational memo issued in February, 2019, regarding changes to Section 4004 of the Agriculture Improvement Act of 2018, Section 2014 of Title 7 of the United States Code (7 U.S.C. § 2014), to make the current option to provide a shelter deduction to homeless households that are not receiving free shelter throughout the month and do not opt to claim an excess shelter deduction mandatory for all states.

The following proposed amendments are submitted as emergency rules to comply with implementation of federal regulations issued in April, 2019, and a USDA Informational Memo Regarding Implementation of Section 4009 of the Agricultural Act of 2014 issued in June, 2019 to:

- (1) update employment and training programs in which students are exempt from student eligibility restrictions; and
- (2) define and count substantial lottery or gambling winnings as countable resources and explain how a household may regain resource eligibility following benefit closure and add a household requirement to report substantial

lottery or gambling winnings within 10-calendar days of receipt and that such a verified change may close food benefits between renewal periods.

The proposed amendment to reduce the percentage of able-bodied adults without dependents that may be exempted from work requirements is submitted as an emergency rule to comply with a USDA informational memo regarding Section 4005 of the Agriculture Improvement Act of 2018, issued in March, 2019.

CONTACT PERSON:

Dena Thayer at 405-521-4326

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 SEPTEMBER 17, 2019, WHICHEVER IS LATER:

SUBCHAPTER 5. NON-FINANCIAL ELIGIBILITY CRITERIA

PART 3. SPECIAL HOUSEHOLDS

340:50-5-29. Homeless households

(a) A household is not required to have a fixed residence in order to receive food benefits. A homeless household may include one or more homeless persons.

(b) Per 271.2 of Title 7 of the Code of Federal Regulations (7 C.F.R. § 271.2), homeless person means a person who lacks a primary and regular nighttime residence or a person whose primary nighttime residence is a:

- (1) supervised shelter designed to provide temporary accommodations;
- (2) half-way house or similar institution providing temporary residence for persons intended to be institutionalized;
- (3) temporary accommodation in the residence of another person of not more than 90-calendar days from the application date. The worker applies the 90-calendar day time frame to each subsequent temporary accommodation in a different household and location; or
- (4) place not designed for, or ordinarily used, as a regular sleeping accommodation for human beings, such as a hallway, bus station, lobby, car, or similar places.

(c) Per 7 C.F.R. § 273.2(f)(4)(v) and Oklahoma Administrative Code 340:50-7-31, when a homeless household incurs or expects to incur a shelter cost during the month, the household is eligible for at the standard homeless shelter deduction, per Oklahoma Department of Human Services Appendix C-3, Maximum Food Benefit Allotments and Standards for Income and Deductions, or the excess shelter deduction, whichever results in the most food benefits for the household. When a homeless household lives in a vehicle and makes Homeless shelter costs may include a monthly payments on the vehicle; the monthly payment is an allowable shelter cost payment when the household lives in the vehicle, payments to friends

or neighbors for sleeping accommodations, camping fees, or hotel or motel charges.

PART 5. STUDENTS, STRIKERS, RESIDENT FARM LABORERS, MIGRANT HOUSEHOLDS, SPONSORED ALIENS, AND SCHOOL EMPLOYEES

340:50-5-45. Students

(a) Supplemental Nutrition Assistance Program (SNAP) eligibility. Persons classified as students per (b) of this Section are not eligible to participate in the Supplemental Nutrition Assistance Program (SNAP) unless they qualify for an exemption per (c) of this Section. Students that do not meet the criteria per (b) of this Section may participate in SNAP when all other eligibility criteria are met.

(b) Student classification. Persons Per Section 273.5 of Title 7 of the Code of Regulations (7 C.F.R. § 273.5), persons are classified as students when they are enrolled at least half-time in an institution of higher education.

- (1) An institution of higher education includes a:
 - (A) business, technical, trade, or ~~vocational~~ vocational school that normally requires a high school diploma or equivalency certificate to enroll in the curriculum. Schools or courses that do not require a high school diploma or equivalency certificate are not considered an institution of higher education; or
 - (B) a college or university that offers degree programs even when a high school diploma or equivalency certificate is not required to enroll. A college includes a junior, community, two-year, or four-year college, or university.
 - (i) Students enrolled at least half time in the **regular curriculum** are considered enrolled in higher education.
 - (ii) Persons enrolled in a special program at a college or university in special programs are not considered enrolled in higher education. Special programs include:
 - (I) courses for such as English as a second language;
 - (II) course or other courses that are not part of the regular degree programs; or
 - (III) Temporary Assistance for Needy Families (TANF) Special Projects Expansion Project program are not considered to be enrolled in higher education.
- (2) Student status begins on the first day of the school term for students who have:
 - (A) not attended an institution of higher education previously; or
 - (B) had a break of more than a semester since they last attended.
- (3) Persons are classified as students during normal periods of class attendance, and through ~~vacations~~ vacation, and other breaks unless the student:

- (4) Persons who graduate, are
 - (i) graduates;
 - (ii) is expelled or suspended;
 - (iii) dropout, drops out; or
 - (iv) have completed school and does not intend to register for the next normal school term, excluding summer school, are no longer considered students.

(bc) Students not subject to eligibility restrictions Student exemptions. The students described in this subsection may participate in the Supplemental Nutrition Assistance Program (SNAP) if when all other eligibility criteria are met. Eligibility restrictions discussed in subsection (c) of this Section do not apply if the students are The student is:

- (1) under age younger than 18 years of age or age 50 or years of age and older;
- (2) physically or mentally unfit.
 - (A) If When the student claims mental or physical unfitness is claimed and the unfitness is not evident to the worker, verification may be required.
 - (B) Appropriate verification may consist of:
 - (i) receipt of temporary or permanent disability benefits issued by governmental or private sources;
 - (ii) participation in a state vocational rehabilitation (VR) program; or
 - (iii) a statement from a physician or licensed or certified psychologist;
- (3) attending high school;
- (4) participating in an on-the-job training (OJT) program. Students are considered participating in OJT programs only during the period of time the students are being trained by the employer;
- (5) attending an institution of higher education less than half time; or
- (6) enrolled half time or more in schools and training programs which are not institutions of higher education.

(e) Eligibility restrictions for students. Persons between the ages of 18 and 50 who are physically and mentally fit and are enrolled at least half time in an institution of higher education may participate in the SNAP only if:

- (44) employed for an average of 20 hours per week or 80 hours per month and paid for that employment. Earning wages equal to the federal minimum wage times 20 is does not a substitute qualify the person for this restriction exemption;
- (25) self-employed for an average of 20 hours per week or 80 hours per month and receives weekly earnings at least equal to the federal minimum wage times 20;
- (36) participating in a state or federally financed work study program during the regular school year.
 - (A) To qualify under this provision, the ~~students~~ student must be approved for work study at the time of application for food benefits.
 - (i) The work study must be approved for the school term and the ~~students~~ student must anticipate actually working during the school term.

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(ii) The exemption begins with the month the school term begins or the month work study is approved, whichever is later.

(iii) Once begun, the exemption continues until the end of the month the school term ends, or it becomes known the ~~students have~~ student refused an assignment.

(B) The exemption does not continue between terms when there is a break of a full month or longer unless the student is ~~participating~~ participates in a work study program during the break;

(47) responsible for the care of a dependent household member under ~~the age of~~ six years of age. Only one person may be considered as responsible for a dependent child. The caretaker need not be the person providing for the child's support;

(58) responsible for the care of a dependent ~~household member~~ child, six through 11 years of age, when the worker determines that adequate child care is not available to enable the student to attend class and work an average of 20 hours per week or participate in a state or federally financed work study program.

(A) The reasons for lack of adequate child care include, but are not limited to, ~~location of the nearest~~ lack of an available licensed and contracted child care facility within a reasonable distance from the student's home or school or the availability of funds to pay child care expenses. Determination of availability of adequate child care is made on a case-by-case basis.

(B) Only one person may be considered as responsible for the care of a dependent child. The caretaker need not be the person providing for the child's support;

(69) a single ~~parents~~ parent enrolled in an institution of higher education on a full-time basis, as determined by the institution, and responsible for the care of a dependent child under age younger than 12 years of age, regardless of the availability of child care.

(A) This provision applies in those situations where only one natural, adoptive, or stepparent, regardless of marital status, is in the same food benefit household as the child.

(B) ~~If~~ When no natural, adoptive, or stepparent is in the same food benefit household as the child, another full-time student in the same food benefit household as the child may qualify for ~~eligible student status under this provision if~~ exemption when he or she has parental control over the child and ~~is not living~~ does not live with his or her spouse;

(710) A Temporary Assistance for Needy Families (TANF) ~~recipients~~ recipient; ~~or~~

(811) assigned to or placed in an institution of higher education through or in compliance with the requirements of one of the employment and training programs identified in (A) through ~~(E)(D)~~ of this paragraph. "In compliance with" means the person self-enrolled in the school during the period of time he or she was enrolled in an employment

and training program and the program has a component for enrollment in an institution of higher education and accepts the placement. Employment and training programs include:

(A) the Workforce ~~Investment~~ Innovation and Opportunity Act (WIA) Program;

(B) a food benefit employment and training program, per 7 C.F.R. § 273.7, subject to the condition that the course or program of study, as determined by Adult and Family Services (AFS) SNAP staff, is:

(i) part of a career and technical education program, per Section 3 of the Carl D. Perkins Career and Technical Education Act of 2006; and Section 2302 of Title 20 of the United States Code (20 U.S.C. § 2302), designed to be completed in not more than four years at an institution of higher education, per Section 102 of the 1998 Amendments to the Higher Education Act of 1965, 20 U.S.C. § 1002; or

(ii) limited to remedial courses, basic adult education, literacy, or English as a second language;

(C) ~~the Job Opportunities and Basic Skills (JOBS) program under Title IV of the Social Security Act;~~

~~(D)~~ a program under Section 236 of the Trade Act of 1974 currently known as The Trade Adjustment Assistance Program and administered by the Oklahoma Employment Security Commission; or

~~(E)~~ a state or local government-operated employment or training program, ~~as determined appropriate by the United States Department of Agriculture, Food and Nutrition Service (FNS)~~ for low-income households where one or more components of the program is at least equivalent to an acceptable SNAP employment and training program as specified, per 7 C.F.R. § 273.7(e)(1) and as determined by AFS SNAP staff; or

(12) enrolled as a result of participation in the Job Opportunities and Basic Skills program under Title IV of the Social Security Act or its successor program.

(d) **Income and deductible expenses of an ineligible student.** When the student is not eligible to receive food benefits, he or she is considered a non-household member per Oklahoma Administrative Code (OAC) 340:50-5-5. His or her income is not considered and household expenses may be prorated, per OAC 340:50-5-6.

PART 10. ABLE-BODIED ADULTS WITHOUT DEPENDENTS

340:50-5-101. Exemption to Able-Bodied Adult Without Dependents (ABAWD) Work Requirements

Per Section 273.24(g) of Title 7 of the Code of Federal Regulations (7 C.F.R. § 273.24(g)), the Oklahoma Department of Human Services (DHS) may provide an exemption from the three-countable months during any 36-month period rule for ABAWDs, per Oklahoma Administrative Code (OAC)

340:50-5-100(b), for up to ~~45~~12 percent of eligible ABAWDs per federal fiscal year.

(1) **Eligible ABAWD.** An eligible ABAWD is a food benefit recipient or applicant denied eligibility solely because he or she received three-countable months during the current 36-month period. This includes an ABAWD, who is not:

- (A) exempt from ABAWD work requirements, per OAC 340:50-5-100(d);
- (B) fulfilling work requirements, per OAC 340:50-5-100(a); or
- (C) receiving Supplemental Nutrition Assistance Program food benefits because he or she regained eligibility for three-consecutive months, per OAC 340:50-5-100(e)(2).

(2) **Tracking.** DHS tracks the number of exemptions used each month and reports the information to the United States Department of Agriculture Food and Nutrition Services regional office on a quarterly basis.

(3) **12 percent exemption.** DHS uses the allowable ~~45~~12 percent exemptions to extend food benefit eligibility for one additional month to ABAWDs whose eligibility was extended more than three-countable months in error.

(B) When the household's winnings exceed the SNAP resource standard for the elderly or disabled, the worker closes the SNAP food benefit for the next advance notice effective date, per Appendix B-2, Deadlines for Case Actions.

(C) The household may regain resource eligibility once the client verifies the winnings are spent down below the resource standard.

(b) The worker accepts the household's statement regarding the value of liquid resources to determine expedited eligibility. Liquid resources include:

- (1) cash on hand;
- (2) checking or savings account balances;
- (3) the cash value of savings certificates; and
- (4) the cash value of stocks or bonds.

(c) The household must verify the value of liquid and non-liquid resources, per OAC 340:50-5-49, when the sponsor's resources must be considered. After subtracting \$1,500 from countable resources, resources cannot exceed ~~\$3,000~~the resource standard for households that contain a member who is disabled or 60 years of age or older or ~~\$2,000~~the resource standard for all other households, per DHS Appendix C-3.

PART 3. INCOME

SUBCHAPTER 7. FINANCIAL ELIGIBILITY CRITERIA

PART 1. RESOURCES

340:50-7-1. Resources considered

(a) Resources are excluded in determining eligibility for the Supplemental Nutrition Assistance Program (SNAP) unless the household:

- (1) applies for expedited service. The worker must include the household's liquid resources as defined at (b) of this Section to determine eligibility for expedited service, per Oklahoma Administrative Code (OAC) 340:50-11-1; ~~or~~
- (2) contains one or more sponsored aliens whose sponsor's resources must be considered, per OAC 340:50-5-49; or
- (3) has substantial lottery or gambling winnings. Per Section 273.11(r) of Title 7 of the Code of Federal Regulations (7 § C.F.R. 273.11(r)), substantial lottery or gambling winnings are defined as a cash prize won in a single game, before taxes or other amounts are withheld equal to, or greater than, the SNAP resource standard for households containing an elderly or disabled household member. Refer to Oklahoma Department of Human Services (DHS) Appendix C-3, Maximum Food Benefit Allotments and Standards for Income and Deductions, for the current resource standard.

(A) The client must provide verification of the winnings from the appropriate lottery commission or gaming facility.

340:50-7-29. Income inclusions

(a) **Sources of income considered.** The worker considers all household income, unless specifically excluded, per Section 273.9(c) of Title 7 of the Code of Federal Regulations (7 § C.F.R. 273.9(c)) and Oklahoma Administrative Code (OAC) 340:50-7-22, in determining monthly gross income. Income is classified as earned or unearned.

(1) When one or more household members are absent from the home, before deciding whether to consider the absent household member's income, the worker must determine if the person returns to the home for part of the month.

(A) Per OAC 340:50-5-2, the worker does not include the absent member in the benefit amount and only counts the portion of his or her income that he or she makes available to the rest of the household when the household member does not return for part of the month.

(B) When the household member returns for part of each month, the worker includes him or her in the benefit amount and counts all of his or her income unless excluded, per OAC 340:50-7-22.

(2) Per OAC 340:50-5-5, the household has the option of including a child receiving a foster payment that includes a payment for kinship care, or a Developmental Disability Services (DDS) room and board payment in the food benefit. When the household chooses not to include the child in the food benefit, the worker does not count the child's income, including the foster or DDS room and board payment.

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- (3) When the household adopts a child previously in the custody of the Oklahoma Department of Human Services (DHS) and receives an adoption subsidy payment for the child, the worker includes the child in the food benefit and counts the child's income, including the adoption subsidy payment.
- (4) When a member of the household becomes the guardian of a child and receives a guardianship payment from DHS, the payment is considered as income. The child for whom the payment is received must be included in the food benefit.
- (b) **Earned income.** Per 7 C.F.R. § 273.9(b)(1), earned income is income a household receives in the form of wages, commission, self-employment, or training allowances, and for which a person puts forth physical labor. Temporary disability insurance payments and temporary workers' compensation payments are considered earned income when payments are employer-funded and the person remains employed. The types of earnings listed in (1) through (4) of this subsection, including money from the sale of whole blood or blood plasma or a DDS payment to an extended family care provider for services rendered in addition to the child's room and board payment, are considered earned income.
- (1) **Wages.** Wages and salaries include sick pay paid by the employer to an employee who plans to return to work when recovered, excess benefit allowance payments, and wages garnished or diverted to pay a third party for a household's expenses. Countable wages for military personnel include any allowance included on the earnings statement, such as the Basic Allowance for Housing (BAH) and the Basic Allowance for Subsistence (BAS).
- (2) **S corporations.** When a household member is a shareholder in an S corporation, he or she may receive profits from the business in two ways; as a salary and/or as a profit share of the business. Both types of income are reported on the household member's personal income tax return. Salary income is considered as earned income and profit share income is considered as unearned income per (c)(7) of this Section.
- (3) **Self-employment.** Refer to OAC 340:50-7-30 for self-employment income procedures.
- (4) **Title I payments of the Domestic Volunteer Services Act.** Countable earned income includes payments paid to a household member under Title I of the Domestic Volunteer Services Act of 1973 as amended per Public Law (P.L.) 93-113, unless excluded, per OAC 340:50-7-22.
- (5) **On-the-job training (OJT).** The worker counts income earned in OJT positions as earned income. This includes OJT provided per Section 3(44) of the Workforce Innovation and Opportunity Act of 2014, P.L. 113-128 for persons 19 years of age or older.
- (c) **Unearned income.** In general, unearned income is income a household receives and is not in the form of wages, self-employment, or training allowances, and for which a person does not put forth physical labor. The income listed in (1) through (6) of this subsection, while not all inclusive, are considered unearned, per 7 C.F.R. § 273.9(b)(2).

- (1) **Assistance payments.** The worker counts payments from a federally-aided public assistance program, such as Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), or assistance programs based on need, such as State Supplemental Payments, as unearned income. When such payments are received by a third party, they are counted as income for the person to whom it is legally owed.

(A) A household's food benefit amount does not increase when the public assistance benefit the household receives under a federal, state, or local means-tested public assistance program is reduced, suspended, or closed because the public assistance program imposed a penalty due to an intentional program violation determined as fraud or a household member's failure to comply with a requirement of that program.

(i) To impose a food benefit sanction, the person must be certified for Supplemental Nutrition Assistance Program (SNAP) benefits at the time of the failure to comply and receiving regular benefits from the other program at the time fraud occurred or the household failed to comply with a substantive program requirement.

(ii) Examples of means-tested public assistance programs include SSI and TANF.

(iii) Substantive requirements are behavioral requirements of that program designed to improve the well-being of the household. For TANF, this includes:

(I) complying with TANF Work requirements, per OAC 340:10-2. OAC 340:10-2-2 explains the TANF penalty considered for SNAP when the household fails to comply with TANF Work activities;

(II) cooperating to obtain child support, per OAC 340:10-10-5;

(III) providing a Social Security number, per OAC 340:10-12-1;

(IV) ensuring school-age children regularly attend school, per OAC 340:10-13-1;

(V) verifying children meet immunization requirements, per OAC 340:10-14-1; and

(VI) not using the TANF benefit in a prohibited business, per OAC 340:10-1-3.

(iv) Procedural requirements that do not trigger a penalty include failing to:

(I) provide verification;

(II) complete an interview; or

(III) complete a benefit renewal.

(v) When a worker is not able to obtain the necessary information and cooperation from another federal, state, or local means-tested welfare, or public assistance program to comply with the provision in (A) of this paragraph, DHS is not held responsible. The worker must make a good faith effort to get the needed information and record the details and results of this effort in the case file.

- (vi) The worker does not reduce, suspend, or close the household's current food benefit amount when the benefits under another assistance program are decreased.
 - (vii) When the worker adds eligible members to the food benefit, the benefit must be adjusted regardless of whether the household is prohibited from receiving benefits for the additional member under another federal, state, local welfare, or public assistance means-tested program.
 - (viii) Changes in household circumstances not related to the penalty imposed by another federal, state, local welfare, or public means-tested assistance program are not affected by the provision in (A) of this paragraph.
 - (ix) The application of the provision in (A) of this paragraph applies for the duration of the imposed penalty or until DHS cannot determine the amount of the penalty.
 - (x) SNAP sanctions extending beyond one year must be reviewed at least annually to determine if the sanction continues to apply.
- (B) The provision in (A) of this paragraph does not apply to persons or households subject to disqualification from SNAP for noncompliance with a comparable work requirement per Title IV of the Social Security Act or an unemployment compensation work requirement.
- (2) **Pension and Social Security.** Annuities, pensions, retirement, veterans' or disability benefits, workers' or unemployment compensation, survivors' or Social Security benefits, and strike benefits are unearned income. When a third party receives Social Security benefits it is counted as income for the person to whom it is legally owed. The worker considers disability payments as:
- (A) unearned income when the person is no longer considered an employee of the company and an agency outside of the company pays the disability benefits; and
 - (B) earned income when the person is still considered an employee of the company and the company pays the disability benefits.
- (3) **Support and alimony.** The worker counts support and alimony payments paid directly to the household from non-household members as unearned income. The worker also counts money deducted or diverted to a third party to pay a household expense as unearned income when the court order directs the payment be made to the household. The worker does not count money the court order states must be paid to a third party as income.
- (4) **Grants, dividends, royalty, and interest payments.** Payments from government sponsored programs, such as Agricultural Stabilization and Conservation Service Programs, grants, dividends, royalties, interest, and all other direct money payments from any source construed to be a gain or profit are considered income. The worker treats income from these sources as unearned income. The household must provide proof of income from

these sources so income can be averaged to determine monthly countable income.

- (5) **Monies withdrawn or dividends that are or could be received by a household from trust funds.** Dividends the household has the option of either receiving as income or reinvesting in the trust are considered income in the month they become available to the household.
- (6) **Department of Veteran's Affairs (VA) Aid and Attendance.** When a person receives VA Aid and Attendance income and does not pay someone outside of the food benefit household to care for him or her, this is considered as countable income. Any portion of the VA Aid and Attendance paid to someone outside of the food benefit household for care is excluded.
- (7) **Profit sharing.** When a household member is a shareholder in an S corporation or a partner in a limited partnership or limited liability company, he or she may receive a distribution or profit share of the business. This is considered as unearned income.
- (d) **Income of excluded household members.** Per OAC 340:50-5-10.1, excluded household members are termed as disqualified or ineligible. The worker does not consider the needs of a disqualified or ineligible household member when determining the household's size for purposes of assigning a benefit level to the household or comparing the household's monthly income with the income eligibility standard, per 7 C.F.R. § 273.11(c)(2)(iv).
- (1) **Disqualified household members.** The worker counts the disqualified household member's income in its entirety as available to the remaining household members, per 7 C.F.R. § 273.11(c)(1)(i). The worker does not prorate utility, medical, dependent care, child support expenses, or excess shelter deductions. Per OAC 340:50-5-10.1, disqualified household members are those excluded for:
- (A) committing an intentional program violation;
 - (B) failing to meet work registration requirements;
 - (C) meeting fleeing felon criteria; or
 - (D) being a probation or parole violator.
- (2) **Ineligible household members.** The worker prorates the income of ineligible household members among all household members, per 7 C.F.R. § 273.11(c)(2)(ii).
- (A) Per OAC 340:50-5-10.1, ineligible household members are those excluded because they do not meet a program requirement, such as:
- (i) failure to obtain or refusal to provide a Social Security number;
 - (ii) not being a citizen or qualified alien; or
 - (iii) being an able-bodied adult without dependents and not meeting work requirements; or
 - (iv) failure to cooperate with providing requested verification regarding unclear information.
- (B) The worker counts a pro rata share of the ineligible household member's income as income available to the remaining members by first subtracting the allowable income exclusions, per OAC 340:50-7-22, from the ineligible member's income

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and dividing the income evenly among the eligible household members and the ineligible member.

(C) The worker counts all but the ineligible member's share as income available to the remaining household members. The earned income deduction, per OAC 340:50-7-31, and DHS Appendix C-3, Maximum Food Benefit Allotments and Standards for Income and Deductions, applies to the prorated income attributed to the household when it was earned by the ineligible member.

(D) The portion of the household's allowable shelter, child support, and dependent care expenses paid by or billed to the ineligible member is divided evenly among the household members, including the ineligible member. All but the ineligible member's share is considered a deductible shelter expense for the remaining household members, with the exception of utility expenses, per 7 C.F.R. § 273.9(d)(6)(iii)(F), or the standard homeless shelter deduction, per 7 C.F.R. § 273.9(d)(6)(i). When the:

(i) household is responsible for utility expenses, the household is allowed the full utility standard for which it qualifies, per OAC 340:50-7-31; or

(ii) homeless household is responsible for shelter costs, the household is allowed the full standard homeless shelter deduction, per Appendix C-3, Maximum Food Benefit Allotments and Standards for Income and Deductions, or the prorated excess shelter deduction incurred by the household, whichever results in the most benefits for the household, per OAC 340:50-7-31(a)(6)(A)(v).

340:50-7-31. Deductions

(a) **Deductible expenses.** Households are allowed certain deductible expenses from income as described in (1) through (6) of this subsection and per Section 273.9(d) of Title 7 of the Code of Federal Regulations (7 C.F.R. § 273.9(d)). The household reports current medical, dependent care, legally-binding child support, and shelter expenses at certification, mid-certification renewal, and certification renewal. The household must also report current shelter costs when the household moves.

(1) **Standard deduction.** All households are allowed a standard deduction, per Oklahoma Department of Human Services (DHS) Appendix C-3, Maximum Food Benefits Allotments and Standards for Income and Deductions.

(2) **Earned income deduction.** Households with earned income are allowed an earned income deduction, per DHS Appendix C-3, to cover the cost of state and local income taxes, pensions, union dues, and work related expenses. Refer to Oklahoma Administrative Code (OAC) 340:50-7-30 for information regarding business expenses for self-employed persons.

(3) **Medical expense deduction.** A medical expense deduction is only allowed for household members meeting the definition of elderly or disabled, per OAC 340:50-5-4.

For these household members, medical expenses exceeding \$35 per month are deductible when verified. The \$35 is subtracted from medical expenses once per household, not per person, when the household has more than one elderly or disabled member.

(A) **Allowable medical expenses.** Allowable medical expenses must be prescribed or approved by a state licensed or qualified practitioner and include:

(i) medical and dental care, including psychotherapy and rehabilitation services provided by a licensed practitioner or other qualified health professional authorized by state law;

(ii) hospitalization or outpatient treatment, nursing care, and nursing home care, including payments by the household for a person who was a household member immediately prior to entering a hospital or nursing home provided by a facility recognized by the state;

(iii) prescription drugs and other over-the-counter medication including insulin, when approved by a licensed practitioner or other qualified health professional authorized by state law. This does not include the cost of a Schedule I controlled substance under the Controlled Substances Act, Section 801 et. seq. of Title 21 of the United States Code, or any expenses associated with its use;

~~(iv) Costs~~ costs of medical supplies, sick-room equipment including rentals, or other prescribed equipment ~~are also included;~~

~~(v) health, dental, and hospitalization policy premiums;~~

~~(vi) Medicare premiums and any cost-sharing or spend-down expenses incurred by Medicare or SoonerCare (Medicaid) recipients;~~

~~(vii) dentures, hearing aids, and prosthetics;~~

~~(viii) eye glasses prescribed by a licensed practitioner;~~

~~(ix) reasonable cost of lodging and transportation to obtain medical treatment or services. Lodging costs are allowed when the elderly or disabled member is required to spend the night away from home to receive medical services. Reasonable transportation costs are based on the type of transportation used. When the elderly or disabled member:~~

~~(I) uses his or her vehicle, the state's current mileage reimbursement is allowed;~~

~~(II) uses public transportation, the actual cost of the transportation is allowed; or~~

~~(III) pays a non-household member for transportation, the amount charged by the person is allowed;~~

~~(x) maintaining an attendant, homemaker, home-health aide, child care services, or housekeeper due to age, infirmity, or illness. When this expense also qualifies as a dependent care expense~~

per (4) of this subsection, it is considered a medical expense rather than a dependent care expense. Additionally, when the household furnishes a majority of the caretaker's meals, an amount equal to one allotment is added to the medical expense for meals provided. The allotment used is the amount in effect at certification; and

~~(xi)~~ costs associated with all service animals specially trained to serve the needs of elderly or disabled program participants. This includes maintenance costs, such as veterinary bills, food, and other expenses for these service animals.

(B) Medical expenses not allowed. Expenses not allowed include:

- (i) costs associated with special diets;
- (ii) premiums for health and accident insurance policies, such as those payable in lump sum settlements for death or dismemberment;
- (iii) premiums for income maintenance policies, such as those that continue mortgage or loan payments while the beneficiary is disabled;
- (iv) items that can be purchased with food benefits, such as dietary supplements; ~~and~~
- (v) the cost of meals or other incidentals when the person spends the night away from home to receive medical services; and
- (vi) prescribed medical marijuana or any expenses associated with its use.

(C) Medical expense verification requirements. Households are required to report and verify medical expenses at certification and certification renewal. Households are not required to report changes in medical expenses during the certification period.

(i) When a household voluntarily reports a reduction in medical expenses that will decrease the food benefit allotment, no verification is needed. However, the change requires notice of adverse action, per OAC 340:50-9-5.

(ii) When a household voluntarily reports additional medical expenses that will increase the food benefit allotment, the household must verify the additional expenses before the worker changes the medical expense deduction.

(iii) When the additional medical expenses are one-time expenses, such as hospital costs, dental expenses, or the purchase of prescription eyeglasses, the expense is only allowed when the person reports and verifies the expense before it becomes past due. When a portion of the expense will be paid by a vendor or insurance payment, the worker does not allow the expense until the amount owed by the person is verified. Once verified, the household may choose to:

- (I) deduct the entire expense in the month incurred or when it becomes due;
- (II) average the expense over the remaining months of the certification period; or

(III) average the expense over the scheduled length of a payment plan.

(iv) When the worker finds out about a change from a source other than the household, the change is acted on when verified upon receipt, such as when the worker is notified via data exchange of a Medicare premium change. The worker does not contact the household for additional information. When the change requires household contact for additional information or verification, the worker does not make the change.

(v) When a household reports but does not verify an anticipated medical expense, the worker informs the household the expense will be allowed when the household provides verification.

(4) Dependent care. Dependent care is payment for the actual cost for the care of a child under 18 years of age or other dependent of any age with disabilities when necessary for a household member to seek, accept, or continue employment or to attend training or education preparatory to employment. Dependent care costs may include activity fees and the cost of transportation to and from the dependent care facility.

(A) The deduction applies regardless of whether the household member is subject to the Supplemental Nutrition Assistance Program Employment and Training requirements.

(B) When the expense also qualifies as a medical expense per (a)(3) of this Section, it is considered a medical expense rather than a dependent care expense.

(C) There is no maximum dependent care deduction. The total reported by the client is an allowable expense as long as it meets the criteria in this Section.

(D) Dependent care is only verified when the expenses claimed actually result in a deduction and other information available to the worker is inconsistent with the household's claim that it incurs a dependent care expense.

(5) Legally-binding child support. A deduction is allowed for verified legally-binding child support payments paid by a household member to or for a non-household member, including payments made to a third party on behalf of the non-household member.

(6) Shelter costs. A household is allowed a shelter deduction when the monthly shelter cost exceeds 50 percent of the household's income after all other deductions are allowed, per 7 C.F.R. § 273.9(d)(6)(ii). The shelter deduction cannot exceed the maximum amount allowed per DHS Appendix C-3, unless the household includes an elderly or disabled member. Households with an elderly or disabled member receive an excess shelter deduction for the monthly cost exceeding 50 percent of the household's income after the deductions listed in (1) through (6) of this subsection are allowed. When the household includes a non-household member or disqualified member, refer to ~~(b)(4)(5)~~ and ~~(5)(6)~~ of this Section to determine whether to prorate shelter costs.

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(A) **Allowable rent or mortgage costs.** Allowable rent or mortgage costs for the

- (i) monthly rent or mortgage payment, or other continuing charges leading to the ownership of the shelter, such as loan repayments for the purchase of a mobile home, including interest on such payments;
- (ii) charge for renting or buying the land on which a mobile home is located;
- (iii) property taxes, state and local assessments, and insurance on the structure. A mobile home is taxed as part of the property tax when the land is owned or being purchased;
- (iv) personal property tax for unregistered mobile homes on rented land; or
- (v) ~~monthly vehicle payment~~ standard homeless shelter deduction, per DHS Appendix C-3, or the excess shelter deduction described, per (a)(6) of this Section, whichever results in the most food benefits for the household, when a homeless household lives in the vehicle incurs or expects to incur a shelter cost.

(B) **Expenses not considered as shelter costs.** The worker does not consider as shelter costs, the cost for:

- (i) insuring furniture or personal belongings when paid separately from the insurance on the home;
- (ii) vehicle registration or a tag for a mobile or motor home; or
- (iii) personal property tax except as allowed, per (6)(A)(iv) of this subsection.

(C) **Allowable utility costs.** When the household incurs utility expenses, it is eligible for one of three standard utility allowances based on criteria in (i) through (iii) of this subparagraph. The applicable utility standard amount is specified, per DHS Appendix C-3.

(i) The standard utility allowance (SUA) is based on annual averages that include costs for heating or cooling; and cooking fuel, electricity, basic phone service, water, sewage, and garbage. This includes households that receive Low Income Heat Energy Assistance Payments (LIHEAP).

(I) The household is eligible for the SUA when the household is billed for heating or cooling during the year. Households billed less often than monthly for heating costs, such as butane or propane may continue to use the utility standard between billing months.

(II) When a household reports they no longer incur a heating or cooling expense, but still have a utility expense, the standard must be changed to the basic utility allowance (BUA) or telephone standard.

(III) When a household's heating or cooling expenses are partially reimbursed or paid by an excluded payment, such as a vendor payment,

Housing and Urban Development (HUD), or Farmers Home Administration (FmHA) payment, the household remains eligible for the SUA.

(ii) The BUA includes utility charges the household incurs other than for heating and/or cooling, such as cooking fuel, water, sewage, garbage collection, and basic phone service.

(iii) The telephone standard is used when the household is not entitled to use the SUA or BUA, but has a phone cost.

(D) **When shelter costs for an unoccupied home are allowed.** Shelter costs for an unoccupied home may be allowable when the household is temporarily away from home because of illness, a disaster or casualty loss to the home, or to attend an employment or training opportunity.

(i) For the cost of a vacated home to be included in shelter costs the:

(I) household must intend to return to the home;

(II) current occupants of the home, if any, must not claim the shelter costs during the household's absence; and

(III) home must not be rented or leased during the household's absence.

(ii) A household that has an occupied home and an unoccupied home is only allowed one standard utility deduction.

(b) **Expense calculation.** The worker calculates a household's expenses based on the expenses the household expects to be billed for during the certification period. The worker anticipates expenses based on the most recent month's bills unless the household is reasonably certain a change will occur.

(1) **Billing fluctuations.** The household may elect to average expenses when the billed amount fluctuates monthly, is billed less often than monthly, or as in the case of some medical expenses, the expense changes throughout the certification period.

(2) **When expenses are owed but not paid.** The household is allowed a deduction in the month the expense is billed or otherwise becomes due, regardless of when the household intends to pay the expense. A particular expense may be deducted only once.

(3) **Reimbursed expenses.** The portion of an expense paid by an excluded reimbursement or vendor payment is not deductible. The amount left after deducting the excluded payment is deductible and includes HUD and Farmers Home Administration (FmHA) rent and utility payments. Expenses are only deductible when the service is provided by someone outside of the household and the household makes a monetary payment for the service.

(4) **One-time expenses.** The household may choose to average one-time expenses over the entire certification period in which they are billed, per 7 C.F.R. § 273.10(d)(3). When the household reports a one-time expense during the certification period, the household may choose to:

(A) deduct the entire expense for the next effective month; or

(B) average the expense over the remaining months in the certification period beginning with the next effective month. When the household is certified for 24 months and the one-time expense was incurred in the:

(i) first 12 months of the certification period, the household may elect to deduct the expense in one month, average the expense over the remaining months in the first 12 months of the certification period or average the expense over the remaining months in the certification period; or

(ii) the second 12 months of the certification period, the household may elect to have the expense deducted in one month or averaged over the remaining months in the certification period.

(5) **When the household includes a disqualified household member.** When the household includes a disqualified household member, per OAC 340:50-5-10.1, the worker does not prorate allowable deductions because the disqualified member's income is counted in its entirety, per OAC 340:50-7-29(d).

(6) **When the household includes an ineligible household member.** When the household includes an ineligible household member, per OAC 340:50-5-10.1, the worker prorates the allowable deductions evenly between the household members, including the ineligible member except for utility expenses, with the exception of (A) and (B) of this subparagraph, because the ineligible member's income is also prorated, per OAC 340:50-7-29(d). When the household is:

(A) When the household is responsible for utility expenses, the household is allowed the full utility standard deduction for which it qualifies per (a)(6)(C) of this Section; or

(B) homeless and incurs shelter costs, the household is eligible for the full standard homeless shelter deduction or for a prorated share of excess shelter deduction, whichever results in more food benefits for the household.

(7) **When the household includes a non-household member.** When the household shares deductible expenses with a non-household member, the worker only deducts the amount the household actually pays or contributes toward household expenses with the exception of the utility expenses. When the household pays part of the utility expenses, the household is allowed the full utility standard deduction for which it qualifies, per (a)(6)(C) of this Section. When the payments or contributions cannot be differentiated, the worker prorates the expenses evenly among persons actually paying or contributing to the expense and deducts only the household's pro rata share with the exception of the utility expenses.

340:50-9-5. Changes after application and during the certification period

(a) **Change reporting requirements.** Section 273.12 of Title 7 of the Code of Federal Regulations (7 C.F.R. § 273.12) contains change reporting requirements after application and during the certification period described in (a) through (i) of this Section.

(b) **Applicant households.** Applicant households must report all changes related to their food benefit eligibility and benefit amount. Households must report changes that occur after the interview but before the date of the notice of eligibility, within 10-calendar days of the date of the notice.

(c) **Annual reporting households.** Annual reporting households are households in which all adult members are elderly or disabled with no earned income.

(1) **Certification period.** A 24-month certification period is automatically assigned to annual reporting households. Annual reporting households must complete a mid-certification renewal between certification periods to report current household circumstances.

(2) **Change reporting between renewal periods.** Between the mid-certification renewal and certification renewal reporting months, the household must report gross income changes when the household's income exceeds the maximum gross income scale for household size shown on Form 08MP006E, Information for Benefit Renewal, and when the household wins substantial lottery or gambling winnings as defined, per 7 C.F.R. § 273.11(r) and Oklahoma Administrative Code (OAC) 340:50-7-1, within 10-calendar days of receipt of the first payment attributable to the change. The maximum gross income scale is based on 130 percent of the monthly poverty income guidelines.

(3) **Action taken on reported changes.** The worker must act on all changes reported by households.

(A) The computer system determines if the change results in an increase, decrease, or no change in benefits.

(B) Between the mid-certification renewal and certification renewal months, the changes the worker makes do not decrease or close benefits until the mid-certification renewal is due unless the:

(i) household's income increase exceeds the maximum gross income scale for household size shown on Form 08MP006E;

(ii) household requested benefit closure;

(iii) worker has information about the household's circumstances considered verified upon receipt, per (g) of this Section; ~~or~~

(iv) a household member is identified as a disqualified or ineligible person, per 7 C.F.R. § 273.12(a)(5)(vi) and ~~Oklahoma Administrative Code (OAC) 340:50-5-10.1; or~~

(v) the worker verifies the household won substantial lottery or gambling winnings as defined, per 7 C.F.R. § 273.11(r) and OAC 340:50-7-1.

SUBCHAPTER 9. ELIGIBILITY AND BENEFIT DETERMINATION PROCEDURES

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- (C) The computer system applies all changes that increase benefits. Before entering a change that increases benefits, verification supporting the change must be provided, when required.
- (d) **Mid-certification renewal for annual reporting households.** Annual reporting households are sent notification in the 11th month of certification that the mid-certification renewal is due. The notice explains methods the household may choose to complete the renewal and required verification needed. An interview is not required.
- (1) **When the mid-certification renewal is due.** The household must complete the benefit renewal and provide required verification by the last day of the 12th month of certification.
- (2) **Completion of mid-certification renewal.** The worker reviews benefit renewal information and verification provided to determine completeness and continued eligibility.
- (A) When the renewal is complete and the household remains eligible, the worker acts on all reported changes and the computer system applies any increase or decrease in benefits.
- (i) When the household fails to provide sufficient information regarding a deductible expense requiring verification, the worker processes the mid-certification renewal without regard to the deduction.
- (ii) When benefits are decreased, an advance notice is sent, per the Oklahoma Department of Human Services (DHS) Appendix B-2, Deadlines for Case Actions.
- (B) When the household is no longer eligible, the worker closes food benefits effective the next advance-notice deadline date, per DHS Appendix B-2.
- (C) When the renewal is incomplete, the computer system closes food benefits effective the next advance-notice deadline date, per DHS Appendix B-2.
- (3) **When benefits may be reopened.** Food benefits may be reopened following closure when criteria is met per (j) of this Section.
- (e) **Semi-annual reporting households.** Food benefit households are considered semi-annual reporting households unless they meet criteria per (b) or (g) of this Section.
- (1) **Certification period.** A 12-month certification period is automatically assigned to semi-annual reporting households.
- (2) **Change reporting between renewal periods.** Between the mid-certification renewal and certification renewal reporting months, the household must report when:
- (A) the household's gross income exceeds the maximum gross income scale for household size shown on Form 08MP006E and when the household wins substantial lottery or gambling winnings as defined, per 7 C.F.R. § 273.11(r) and OAC 340:50-7-1 within 10-calendar days of receiving the first payment attributable to the change. The maximum gross income scale is based on 130 percent of the monthly poverty income guidelines; and
- (B) a decrease in work hours below an average of 20 hours per week or 80 hours per month occurs for any household member meeting the able-bodied adults without dependents (ABAWD) work rules, per OAC 340:50-5-100 by the 10th of the following month.
- (3) **Action taken on reported changes.** The worker must act on all changes reported by households.
- (A) The computer system determines if the change results in an increase, decrease, or in no change in benefits.
- (B) Between mid-certification renewal and certification renewal months, the changes the worker makes do not decrease or close food benefits until the mid-certification renewal is due unless:
- (i) the household's income increase exceeds the maximum gross income scale for household size shown on Form 08MP006E;
- (ii) the household requested benefit closure;
- (iii) the worker has information about the household's circumstances considered verified upon receipt, per (h) of this Section;
- (iv) an ABAWD must be removed from the food benefit household because he or she does not meet the ABAWD work rule, per OAC 340:50-5-100;
- (v) a household member is identified as a disqualified or ineligible person, per 7 C.F.R. § .27312(a)(5)(vi) and OAC 340:50-5-10.1; ~~or~~
- (vi) a household member is identified as failing to meet work registration requirements, per OAC 340:50-5-85 through OAC 340:50-5-87; or
- (vii) the worker verifies the household won substantial lottery or gambling winnings as defined, per 7 C.F.R. § 273.11(r) and OAC 340:50-7-1.
- (C) The computer system applies all changes that increase benefits. Before entering a change that increases benefits, verification supporting the change must be provided, when required.
- (f) **Mid-certification renewal for semi-annual reporting households.** Semi-annual reporting households are sent notification in the fifth month of certification that the mid-certification renewal is due. An interview is not required.
- (1) **When the mid-certification renewal is due.** The household must complete the benefit renewal and provide required verification by the last day of the sixth month of certification.
- (2) **Completion of mid-certification renewal.** The worker reviews benefit renewal information and verification provided to determine completeness and continued eligibility.
- (A) When the renewal is complete and the household remains eligible, the worker acts on all reported changes and the computer system applies any increase or decrease in benefits.

- (i) When the household fails to provide sufficient information regarding a deductible expense requiring verification, the worker processes the mid-certification renewal without regard to the deduction.
- (ii) When benefits are decreased, the worker sends an advance notice, per DHS Appendix B-2, Deadlines for Case Actions, deadline dates.
- (B) When the household is no longer eligible, the worker closes food benefits effective the next advance-notice deadline date, per DHS Appendix B-2.
- (C) When the renewal is incomplete, the computer system closes food benefits effective the next advance-notice deadline date, per DHS Appendix B-2.
- (3) **When benefits may be reopened.** Food benefits may be reopened following closure when criteria is met per (i) of this Section.
- (g) **Change reporting households.** Change reporting households are assigned a certification period other than 12 or 24 months. These households are required to report changes within 10-calendar days of when the change occurred.
 - (1) **Household characteristics.** Households not approved for a 12- or 24-month certification period include households approved for:
 - (A) expedited services for one or two months because the interview and/or verification were postponed, per OAC 340:50-3-2; and
 - (B) a three- or four-month certification period because the household includes one or more ABAWDs that do not meet the work rule, per OAC 340:50-5-100.
 - (2) **Required change reporting.** These households must report changes in:
 - (A) sources of income;
 - (B) unearned income of \$100 per month or more;
 - (C) earned income of more than \$100 per month;
 - (D) household composition, such as an addition or loss of a household member;
 - (E) residence and shelter costs;
 - (F) the legal obligation to pay child support; ~~and~~
 - (G) the work hours of an ABAWD subject to benefit time limits, per OAC 340:50-5-100 when they fall below 20 hours per week; and
 - (H) resources when the household wins substantial lottery or gambling winnings as defined, per 7 C.F.R. § 273.11(r) and OAC 340:50-7-1.
 - (3) **Action taken on case changes.** The worker must act on changes reported by the household within 10-calendar days of the date the household reported the change and provided necessary verification.
 - (A) When the household fails to report a change within the 10-calendar day period and, as a result, receives benefits to which it is not entitled, an overpayment claim is referred to Adult and Family Services (AFS) Benefit Integrity and Recovery, per OAC 340:50-15.
 - (B) When the worker fails to take timely action on a reported change and benefits are lost, the worker supplements the household's food benefits.
- (4) **Changes that increase benefits.** When the household reports a change that increases benefits the household must verify the information before the worker makes the change. The worker gives the household 10-calendar days to verify the information.
- (5) **Changes that decrease or close benefits.** When the household reports a change in household circumstances that decreases or closes food benefits, the worker gives or sends the household Form 08AD092E, Client Contact and Information Request, giving the household 10-calendar days to provide verification of the change. When the household provides required verification, the worker reduces or closes food benefits based on the verification provided. When the household does not provide required verification, the worker closes the food benefits based on the household's failure or refusal to provide verification.
 - (A) When a household's benefit decreases or closes, an advance notice of adverse action is required unless exempt from such notice for a reason listed in (i) or (ii) of this subparagraph. Per 7 C.F.R. § 273.13, advance notice of adverse action is considered timely when the notice is mailed at least 10-calendar days before the action becomes effective. The household retains its right to a fair hearing and continuation of benefits when a fair hearing is requested within 10-calendar days of the change notice. An adverse action notice may be mailed just prior to the date the household receives or would have received benefits when the:
 - (i) DHS receives a clear written statement signed by a responsible household member:
 - (I) stating the household no longer wishes to receive food benefits; or
 - (II) giving information that requires closure or reduction of food benefits and stating that the household understands the food benefit will be reduced or closed; or
 - (ii) worker closes or reduces food benefits per notice requirements at (k)(3)(A) of this Section.
 - (B) When an advance notice is required, the benefit decrease or closure is effective the next advance notice deadline date, per DHS Appendix B-2. When the household reports a change:
 - (i) 10-calendar days or more before the advance-notice deadline, per DHS Appendix B-2, the worker decreases or closes the food benefit effective the first of the following month; or
 - (ii) less than 10-calendar days before the advance-notice deadline, per DHS Appendix B-2, the worker must take action before the advance-notice deadline the following month.
 - (C) When a reported change increases food benefits, the worker makes the change by the non-advance-notice deadline date, per DHS Appendix B-2.

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(h) **Changes considered verified upon receipt.** Verified upon receipt means the information is not questionable and the provider is the primary source of the information. For example, when DHS receives Social Security and Supplemental Security Income verification through data exchange with the Social Security Administration (SSA), it is considered verified upon receipt because SSA is the primary source. When the worker receives information considered verified upon receipt, he or she makes the change within 10-calendar days of notification using DHS Appendix B-2 deadline dates.

(i) **Required action on unclear information.** During the certification period, the worker may obtain unclear information about a household's circumstances that may affect the household's continued eligibility or benefit amounts. The worker may receive the unclear information from a third party, such as a data exchange discrepancy, an employer, or a person claiming knowledge of the household's circumstances. Unclear information is information that is not verified or is verified but the worker needs additional information before acting on the change.

(1) Per 7 C.F.R. § 273.12(c)(3)(i), when the worker receives unclear information in a non-report month for semi-annual or annual reporting households or any month for change reporters, he or she sends Form 08AD092E to the household; ~~to inform it of required verification or actions. The household must clarify/verify~~ its circumstances within 10-calendar days only when the unclear information:

(A) significantly conflicts with the information used at the time of the certification, indicating the household may have failed to report eligibility information at application; or

(B) is fewer than 60-calendar days old, relative to the current participation month and when true, must be reported under the household's reporting responsibilities.

(2) When the household provides the requested verification in a non-report month, the worker determines whether to take action, per requirements at (c)(3) and (e)(3) of this Section.

(3) When the worker sends Form 08AD092E, per (i)(1)(A) or (B) of this Section, and the household does not respond or responds but refuses to provide sufficient information to clarify its circumstances, the worker closes the household's food benefits effective the next advance-notice deadline date, per DHS Appendix B-2;

(4) Per 7 C.F.R. § 273.12(c)(3)(iii), when the worker receives a data match that indicates a household member may have died or may be incarcerated for more than 30-calendar days, the worker sends Form 08AD092E to the household notifying it of the discrepancy and requesting information regarding the household member.

(A) When the household is a change reporting household and:

(i) fails to respond to Form 08AD092E or responds but refuses to provide sufficient information to clarify the person's household status, the worker closes the household's food benefits;

(ii) responds and verifies the person is not dead or incarcerated, no action is taken; or

(iii) responds and confirms the accuracy of the data exchange information, the worker removes the person from the food benefit and determines if an overpayment referral is needed, per OAC 340:50-15.

(B) When the household is an annual or semi-annual reporting household and:

(i) fails to respond to Form 08AD092E or responds but refuses to provide sufficient information to clarify the person's household status, the worker removes the person and his or her income from the household and adjusts the food benefits;

(ii) responds and verifies that the person did not die or is not incarcerated, no action is taken; or

(iii) responds and confirms the accuracy of the data exchange information, the worker removes the person and his or her income from the household, adjusts the food benefits, and determines if an overpayment referral is needed, per OAC 340:50-15.

(j) **When benefits may be reopened following closure.** The food benefit may be reopened following closure using current eligibility information, when:

(1) DHS did not administer policy and procedures correctly. The food benefit is reopened effective the first day of the month of closure;

(2) the household fails to complete the mid-certification renewal timely, but provides all required verification by the first day of the month of closure. The food benefit is reopened effective the first day of the month of closure; or

(3) the household fails to complete the mid-certification renewal timely, but provides all required verification by the last day of the month of closure. The food benefit is reopened and prorated from the date the household completes the mid-certification renewal and provides all required verification.

(k) **Notice requirements.** DHS is required to send a notice to the household when food benefits increase, reduce, or close.

(1) **Advance notice of adverse action required.** Prior to reducing or closing food benefits during the certification period, per 7 C.F.R. § 273.13, the worker must provide timely advance notice unless circumstances described in (k)(2) or (3) of this Section occur.

(A) Advance notice of adverse action is considered timely when the notice is mailed at least 10-calendar days before the action becomes effective. Refer to DHS Appendix B-2 for advance notice processing deadlines.

(B) When the household reports a change:

(i) 10-calendar days or more before the advance notice of adverse action deadline, the worker decreases or closes the food benefit effective the first of the following month. For example, when the household reports a change on May 18th, the effective date of the change is June 1st; or

- (ii) less than 10-calendar days before the advance notice of adverse action deadline, per DHS Appendix B-2, the worker decreases or closes the food benefit effective the first of the month after the following month. For example, when the household reports a change on May 25th, the effective date of the change action is July 1st.
- (2) **Notice requirement when benefits increase.** When a reported change increases food benefits, the worker makes the change by the non-advance notice deadline date, per DHS Appendix B-2. When the change is reported after the non-advance notice deadline, the worker supplements food benefits.
- (3) **Advance notice of adverse action not required.** Advance notice of adverse action is not required for actions (A) through (H) of this paragraph, per 7 C.F.R. § 273.12(e) and 7 C.F.R. § 273.13(b).
 - (A) **Mass changes.** When DHS initiates mass changes because of changes or requirements in federal or state law, the computer system closes benefits by the non-advance-notice deadline, per DHS Appendix B-2. In these situations, the individual notification requirement is waived and AFS mails generic notices to the affected households informing them of the changes that are about to be made.
 - (B) **Deceased household members.** When the worker determines, based on reliable information, that all members of the household are deceased, the worker closes benefits by the non-advance-notice deadline, per DHS Appendix B-2.
 - (C) **Moved out of state.** When the worker determines, based on reliable information, the household moved out of state, the worker closes benefits by the non-advance-notice deadline, per DHS Appendix B-2.
 - (D) **Unfinished issuance certification.** When the unfinished issuance process is used at certification, the worker adjusts the benefit to take into account changes anticipated at the time of certification. The certification notice informs the household of all benefit changes included in this process.
 - (E) **Disqualified household member.** When the only household member is disqualified for an intentional program violation or fraud, per OAC 340:50-15-25, food benefits are closed by the non-advance-notice deadline, per DHS Appendix B-2. When there is more than one person in the household, the remaining household members' benefits are reduced or closed because of that household member's disqualification by the non-advance-notice deadline, per DHS Appendix B-2.
 - (F) **Facility loses approval.** When a household's food benefit closes because the drug or alcohol treatment center or group home facility where the household resides is no longer approved, the worker closes benefits by the non-advance-notice deadline, per DHS Appendix B-2.

- (G) **Household provides written statement.** The worker closes or reduces benefits by the non-advance-notice deadline, per DHS Appendix B-2, when the household provides a written statement:
 - (i) stating the household no longer wants to receive food benefits; or
 - (ii) requesting closure or reduction in food benefits to avoid or repay an overpayment.
- (H) **Case transfer.** When the worker closes food benefits in one case in order to transfer the food benefits to another case without a decrease or disruption in benefits, the worker closes benefits by the non-advance-notice deadline, per DHS Appendix B-2.
- (I) **Action on changes when fair hearings are requested.** When a household requests a fair hearing within 10-calendar days of the date shown on an adverse action notice, the worker must reopen or restore food benefits to the previous level pending the outcome of the hearing unless the household specifically waives continuation of benefits, per 7 § C.F.R. 273.15(k). Refer to OAC 340:2-5 for fair hearing procedures.

[OAR Docket #19-793; filed 10-21-19]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 25. OTHER LICENSEES

[OAR Docket #19-794]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

- Subchapter 29. Pharmacy Benefits Managers
- 365:25-29-1. Purpose [AMENDED]
- 365:25-29-2. Scope [AMENDED]
- 365:25-29-3. Authority [AMENDED]
- 365:25-29-4. Definitions [AMENDED]
- 365:25-29-5. Forms and contents of application for PBM license [AMENDED]
- 365:25-29-6. Surety bond [AMENDED]
- 365:25-29-7.1. Retail pharmacy network access - audit [NEW]
- 365:25-29-9. Contractual requirements ~~maximum allowable cost~~ [AMENDED]
- 365:25-29-10. Penalty for noncompliance [AMENDED]
- 365:25-29-12. Commissioner's authority - advisory committee [NEW]
- 365:25-29-13. Claims payment [NEW]
- 365:25-29-14. Inquiry/complaint handling process [NEW]
- 365:25-29-15. Examinations of PBMs and health insurers [NEW]

AUTHORITY:

Insurance Commissioner; 36 O.S. §§ 307.1, 6968-6968, 59 O.S. § 358(B)

ADOPTION:

October 10, 2019

EFFECTIVE:

Immediately upon Governor's approval or November 1, 2019, whichever is later

APPROVED BY GOVERNOR:

October 22, 2019

EXPIRATION:

Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The rule amendments are necessary to implement HB 2632 codified at 36 O.S. §§6958-6968.

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GIST/ANALYSIS:

365:25-29-1 through 365:25-29-4, 365:25-29-6 and 365:25-29-9 through 365:25-29-10 are amended due to the implementation of 36 O.S. §§ 6958-6968. 365:25-29-5 is amended for clarification. 365:25-29-7.1 and 365:25-29-12 through 365:25-29-15 are added due to the implementation of 36 O.S. §§ 6958-6968.

CONTACT PERSON:

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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 NOVEMBER 1, 2019 WHICHEVER IS LATER:

SUBCHAPTER 29. PHARMACY BENEFITS MANAGERS

365:25-29-1. Purpose

The purpose of this Subchapter is to ~~set~~

(1) Set forth the regulations and procedures relating to the licensing and oversight of pharmacy benefits managers under 59 O.S. §§ 357-360, and

(2) Set forth the regulations and procedures relating to the Patient's Right to Pharmacy Choice Act, 36 O.S. §§ 6958-6968.

365:25-29-2. Scope

This Subchapter shall apply to all pharmacy benefits managers, which must be licensed pursuant to 59 O.S. § 358(A), ~~and to all health insurers subject to compliance with~~ 36 O.S. § 6958 et seq.

365:25-29-3. Authority

This Subchapter is promulgated under the authority granted to the Insurance Commissioner in 59 O.S. § 358(B) ~~and~~ 36 O.S. §§ 6958-6968.

365:25-29-4. Definitions

All definitions contained in 59 O.S. §§ 357-360 and 36 O.S. §§ 6958-6968 are applicable to this Subchapter and in addition:

(1) **"Day"** means a calendar day, unless otherwise defined or limited.

(2) The **"act"** means 59 O.S. §§ 357-360 and 36 O.S. §§ 6858-6968.

(3) Pharmacy benefits manager and PBM may be used interchangeably in this Subchapter.

(4) **"Preferred participating pharmacy"** means a pharmacy that is designated as a preferred participating pharmacy in a PBM's retail pharmacy network.

(5) **"Provider"** means an Oklahoma licensed retail pharmacy.

365:25-29-5. Forms and contents of application for PBM license

An application for PBM License shall be on a form provided by the Commissioner and shall include:

(1) The identity of the PBM and any company or organization controlling the operation of the PBM, including the name, business address, and contact person for the PBM and the controlling entity. For purposes of this subsection, "control" or "controlling" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the PBM, whether through the ownership of voting securities, by contract or otherwise, unless, for an individual, the power is the result of an official position with or corporate office held by the person;

(2) The name and address of the corporate officers and directors, members and managers (if an LLC), or names of all partners (if a partnership) of the applicant PBM;

(3) A license fee in the amount of One Thousand Dollars (\$1,000.00);

(4) A "Certificate of Incorporation" or comparable organizational document from the domiciliary state of the PBM;

(5) In the case of a PBM domiciled ~~without~~ outside the State of Oklahoma, a certificate that the PBM is in good standing in the state of domicile or organization;

(6) A report of the details of any suspension, sanction, penalty or other disciplinary action relating to the PBM and its officers and directors;

(7) The name and address of the agent of record for services of process in Oklahoma;

(8) The number of total covered individuals or lives served under all of the PBM's contracts or agreements in Oklahoma;

(9) The most recently concluded fiscal year-end financial statements for the PBM and its controlling entity, which statements have been audited by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP); and

(10) A certificate signed by an Executive Officer of the PBM attesting to the accuracy of the information contained in the filing.

365:25-29-6. Surety bond

(a) Prior to the issuance of a pharmacy benefits manager license, the PBM applicant shall file with the Commissioner and thereafter keep in effect, as long as the license remains in effect, a surety bond in an amount determined to be sufficient by the Commissioner. The bond shall be in a form acceptable to the Commissioner and for the purpose of securing conformity with the laws and regulations governing pharmacy benefits managers. The bond shall be for the benefit of parties protected by the provisions of 59 O.S. §§ 357-360 and 36 O.S. §§ 6958-6968.

(b) The surety bond must provide that no party may cancel the bond without first giving thirty (30) days written notice to the principal and the Commissioner.

(c) Absent a finding otherwise, a bond, shall be deemed to be sufficient if it meets the following requirements:

- (1) For a PBM with not more than five thousand (5,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of fifty thousand dollars (\$50,000.00);
- (2) For a PBM with more than five thousand (5,000) but not more than ten thousand (10,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of one hundred thousand dollars (\$100,000.00);
- (3) For a PBM with more than ten thousand (10,000) but not more than twenty-five (25,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of two hundred fifty thousand dollars (\$250,000.00);
- (4) For a PBM with more than twenty-five thousand (25,000) but not more than fifty thousand (50,000) annual Oklahoma lives covered, the bond shall have a minimum penal sum of five hundred thousand dollars (\$500,000.00);
- (5) For a PBM with more than fifty thousand (50,000) but not more than one hundred thousand (100,000) annual Oklahoma lives covered, the bond shall have a minimum penal sum of seven hundred fifty thousand dollars (\$750,000.00); and
- (6) For a PBM with more than one hundred thousand (100,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of one million dollars (\$1,000,000.00).

365:25-29-7.1. Retail pharmacy network access - audit

(a) Standards:

- (1) Section 6960 of the act defines "member of a retail pharmacy network" as meaning retail pharmacy providers contracted with a PBM on behalf of a payor in which the pharmacy primarily fills and sells prescription medicine via retail storefront location.
- (2) The act draws no distinction between regular or specialty drugs, both being prescription medications, therefore, specialty drugs fall within the contemplation of the act.
- (3) Pharmacy benefits managers shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers.

(b) A PBM's retail pharmacy network access shall be monitored for compliance with this act by those insurers that utilize the services of such PBM. Health insurers are required to maintain retail pharmacy network access in conformity with the requirements set forth in § 6961 of this act.

(c) Every Insurer that utilizes the services of a PBM shall, as part of the annual general compliance audit required by 365:25-29-9, conduct a network adequacy audit. If the audit reveals the percentage of covered individuals is less than one hundred and five percent (105%) above any of the required percentages in 36 O.S. § 6961 the insurer shall conduct semi-annual network adequacy audits until such time that an audit indicates that the percentage of covered individuals is more than five percent 5% above the required percentage.

(d) The audits must be completed within ninety (90) days of the effective date of 36 O.S. § 6958-6968 and annually each year thereafter. The results of the audits shall be reported to the Commissioner within thirty (30) days of the completion of the audit.

365:25-29-9. Contractual requirements—~~maximum allowable cost~~

(a) Maximum Allowable Cost.

(1) Contracts between a PBM and a provider shall conform to the following requirements:

(A4) Identify sources of information utilized by the PBM to create and modify the PBM's maximum allowable cost price specific to the pharmacy;

(B2) The PBM shall provide an electronic process, including but not limited to e-mail, for its pharmacy providers to readily access the MAC list specific to that provider. Upon a provider's written request, a PBM shall furnish its MAC list to the provider in paper form or other agreed format;

(C3) If a provider is unable to obtain a drug from a regional or national wholesaler at a price equal to or less than the PBM's multisource drug product reimbursement, the PBM shall provide a reasonable appeals procedure to contest the multisource drug product reimbursement amount;

(D4) A "reasonable appeals procedure" means a process which permits a provider or a provider's representative to contest a multisource drug product reimbursement amount based on the provider's contention that the drug is not generally available for purchase by Oklahoma pharmacies in the state at or below the PBM's multisource drug product reimbursement;

(E5) A provider's appeal shall contain information including but not limited to the date of claim, National Drug Code number, and the identity of the national or regional wholesalers from which the drug was found to be unavailable for purchase by the provider, at or below the PBM's multisource drug product reimbursement;

(F6) Appeals filed under this subsection shall be presented to the PBM within ten (10) business days following the final adjusted payment date. The PBM must respond to a provider within ten (10) business days following the receipt by the PBM of the notice that the provider is contesting the multisource drug product reimbursement amount;

(G7) If a provider's appeal is denied, the PBM shall provide the reason for the denial, including the National Drug Code number and the identity of the national or regional wholesalers from whom the drug was generally available for purchase by providers in the state at or below the PBM's multisource drug product reimbursement;

(H8) If a provider's appeal is found to be justified, the PBM shall make a change in the multisource drug product reimbursement amount, permit the provider

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to reverse and re-bill the claim in question, and make the multisource drug product reimbursement amount change applicable prospectively for all similarly contracted Oklahoma providers.

(2b) A PBM shall permit the submission of either paper or electronic documentation to perfect an appeal. A PBM shall not require the submission of appeals on an individual claim (non-batch) basis or refuse to accept appeals from a provider's designated representative or require procedures that have the effect of obstructing or delaying the appeal process. All multisource drug product reimbursement appeals shall be properly documented.

(3e) Before beginning business, and as contracts are amended thereafter, each PBM shall submit to the Insurance Commissioner a certificate signed by an executive officer of the PBM attesting that the Oklahoma provider contracts utilized by such PBM satisfy the requirements of 59 O.S. § 360 and this subchapter of the act.

(b) The relationship between a PBM and an insurer or other payor is controlled by contract whereby the PBM acts on behalf of the payor to facilitate the delivery of prescription medication benefits provided by such payor. Requirements and limitations contained within the act and applicable to such payors must be understood within this payor - contractor relationship.

(c) The act requires or limits certain conduct in the interaction between the PBM and retail pharmacy network providers. Consequently, the Department hereby requires that every insurer utilizing the services of a pharmacy benefit manager shall be responsible, as follows:

(1) for approving all contractual documents utilized by its contracted PBMs and its retail pharmacy network to ensure compliance with the act;

(2) for conducting an annual audit of transactions and practices utilized by its contracted PBMs and members of its retail pharmacy network to ensure compliance with the act; and

(3) any exceptions found shall be reported to the Department pursuant to the Commissioner's examination authority.

365:25-29-10. Penalty for noncompliance

(a) After notice and opportunity for hearing, and upon determining that the PBM has violated any of the provisions of 59 O.S. §§ 357-360 of the Oklahoma Statutes, or this Subchapter as it relates to 59 O.S. §§ 357-360, or upon finding the existence of grounds to refuse the issuance or renewal of such license, the Commissioner may suspend or revoke a PBM's license or assess a civil penalty of not less than Five Hundred Dollars (\$500.00) nor more than Five Thousand Dollars (\$5,000.00) for each instance of violation, or both. Each day that a pharmacy benefits manager conducts business in the State of Oklahoma without a license shall be deemed to be an instance of violation. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(b) ~~Every PBM upon receipt of any inquiry from the Commissioner or the Commissioner's representative shall within~~

~~thirty (30) days from the date of inquiry, furnish the Commissioner or the Commissioner's representative with an adequate response to the inquiry.~~

(b) After notice and opportunity for hearing, and upon determining that the PBM has violated any of the provisions of 36 O.S. §§ 6958-6968 of the Oklahoma Statutes, or this Subchapter as it relates to 36 O.S. §§ 6958-6968, the Commissioner may suspend or revoke a PBM's license and/or levy fines not to exceed Ten Thousand Dollars (\$10,000.00) for each count for which any PBM has violated the provisions of 36 O.S. §§ 6958-6968. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(c) After notice and opportunity for hearing, and upon determining that the health insurer has violated any of the provisions of 36 O.S. §§ 6958-6968 of the Oklahoma Statutes, the Commissioner may suspend or revoke a health insurer's certificate of authority license or assess a civil penalty of not less than Five Hundred Dollars (\$500.00) nor more than Five Thousand Dollars (\$5,000.00) for each instance of violation, or both. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(d) Every health insurer upon receipt of any inquiry from the Commissioner or the Commissioner's representative shall, within thirty (30) days from the date of inquiry, furnish the Commissioner or the Commissioner's representative with an adequate response to the inquiry.

365:25-29.12. Commissioner's authority - advisory committee

(a) Pursuant to 36 O.S. § 6966, the Insurance Commissioner shall establish an advisory committee composed of representatives from the following constituent groups:

- (1) Oklahoma Pharmacists Association;
- (2) Office of the Oklahoma Attorney General;
- (3) Consumers; and,
- (4) Insurers or PBMs.

(b) The advisory committee shall function in an advisory capacity only. Any investigation or enforcement action in consequence of the act shall be at the sole discretion of the Commissioner.

(c) Nominees for members of the advisory committee as provided in § 6966 (C) shall be representative of the interests of the stakeholders listed above and shall be submitted to the Commissioner for appointment.

(d) Because committee members will be dealing with confidential, proprietary, or competitively sensitive information the Commissioner shall implement the following protections to prevent such information from being viewed or used inappropriately:

- (1) Advisory committee members shall avoid conflicts of interest and recuse themselves from being involved in any proceedings where they may have insight into a competitor's pricing or proprietary information. The committee members must also avoid any conduct which could be viewed as a conspiracy to fix prices or otherwise restrict competition.

(2) Committee members shall be required to sign conflict of interest forms that disclose potential conflicts before serving on the committee, and affirmatively recuse themselves when a potential conflict arises. A conflict arises when a committee member has a financial stake in the outcome of a complaint or issue before the committee, or has an existing contract with a PBM, pharmacy, or insurer that is the subject of the committee's review. In addition, committee members shall be required to sign confidentiality commitments that acknowledge the statutory prohibition of any disclosure of confidential information that is available to the committee.

(3) All committee nominations must be supported by a National Association of Insurance Commissioners biographical affidavit and background check.

(e) Meetings of the advisory committee shall be convened by the Commissioner upon ten (10) days prior written notice or waivers thereof. The Commissioner or Commissioner's designee may attend any or all meetings of the committee.

365:25-29-13. Claims payment

Payment of claims arising under the terms and conditions of any policy of a medical insurance health benefit plan is the obligation of the insurer that issues such policy. Failure to properly handle such claims is addressed by other provisions of Title 36.

365:25-29-14. Inquiry/complaint handling process

(a) Complaints alleging failure by the PBM to comply with the act, shall be made in writing to the Commissioner, supported by evidentiary materials. All complaints must include a completed "PBM Complaint Form" as promulgated by the Commissioner.

(b) All audits of PBMs by health insurers shall include a review of complaints against the PBM to determine compliance with the terms of the contract between the PBM and the complainant.

(c) PBMs must provide the complainant with a written notice as to the final disposition of the complaint.

(d) As part of its response to the Department in connection with every complaint, the PBM must provide a statement to the Department that the complaint was carefully reviewed and could not be resolved under the terms and conditions of the contract.

365:25-29-15. Examinations of PBMs and health insurers

(a) Pursuant to 36 O.S. § 6965, the Commissioner may examine PBMs for compliance with the 59 O.S §§ 357-360 and 36 O.S. §§ 6958-6968.

(b) Pursuant to 36 O.S. § 309.1 through 309.7, the Commissioner may examine health insurers for compliance with 36 O.S. §§ 6958-6968.

(c) Any examination permitted under 36 O.S. § 6965 will follow the examination procedures and requirements applicable to insurers under 36 O.S. §§309.1 through 309.7.

(d) The Commissioner shall not be required to regularly examine a PBM under the same time constraints, as required under 36 O.S. §§ 309.1 through 309.7, applicable to insurers, however, the Commissioner may examine the PBM, pursuant to 36 O.S. § 6965, at any time, in which he or she believes it reasonably necessary to ensure compliance with 59 O.S §§ 357-360 and 36 O.S. §§ 6958-6968 or provisions of this subchapter.

[OAR Docket #19-794; filed 10-22-19]

**TITLE 465. OKLAHOMA MOTOR VEHICLE COMMISSION
CHAPTER 10. LICENSE**

[OAR Docket #19-802]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 3. ~~License Identification Licenses and Changes~~Registration
465:10-3-1 [AMENDED]
465:10-3-3 [AMENDED]
465:10-3-5 [AMENDED]
465:10-3-6 [NEW]

AUTHORITY:
Oklahoma Motor Vehicle Commission; Title 47, Section 563(F), 564, and Title 75, Section 302(A)(2)

ADOPTION:
September 10, 2019

APPROVED BY GOVERNOR:
October 2, 2019

EFFECTIVE:
November 1, 2019

EXPIRATION:
Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

FINDING OF EMERGENCY:
Title 47, Section 564.2 directs the OMVC to promulgate rules and procedures necessary for the implementation and creation of the registry and the issuance of certificates of registration due to the passage of HB1094 effective November 1, 2019

GIST/ANALYSIS:
HB1094 removes the statutory requirement for salesperson licensing and replaces with a requirement for salesperson registration. Therefore, the first three amended sections remove any reference of salesperson "license", "licensing" and substituting with verbiage "registration" "registered" or "certificate of registration". The new section is required to comply with the Oklahoma Tax Commission's law, Title 47, Section 1128(A) concerning a licensed salesperson's exemption from the 72 hour limit on operating a motor vehicle with a dealer's tag affixed.

CONTACT PERSON:
Marilyn Maxwell (405) 607-8227, Marilyn.Maxwell@omvc.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), WITH A LATER EFFECTIVE DATE OF NOVEMBER 1, 2019:

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SUBCHAPTER 3. LICENSE IDENTIFICATION LICENSES AND CHANGES REGISTRATIONS

465:10-3-1. Purpose

The rules in this subchapter outline additional requirements for licensing of dealers and dealerships, registration of salespersons and renewal of those licenses and registrations.

465:10-3-3. Salespersons' license registration

(a) **License Registration.** Contemporaneous with the employment of a new Salesperson being employed, an application for Salesperson License registration shall be submitted to the Commission on forms prescribed by the Commission along with the appropriate fee paid by the employing licensed dealer. A license certificate of registration for a Motor Vehicle Salesperson will ~~not be issued,~~ issued renewed, or endorsed until the employing Dealer is licensed and has certified that the applicant for said license is in his or her employ. It is not intended that the Dealer pay for licenses for its Salespersons. However, for convenience, the Dealer may do so on a reimbursable basis or any other plan satisfactory to its organization by the Commission within ten days of receipt of a completed application and the proper fee. All Salespersons' licenses—certificates of registration will be sent to the Dealer for distribution to his or her respective applicants, and the Dealer will determine that all its personnel required to obtain license be registered have done so. Salesperson License registrations are required for anyone involved in the selling of new or used vehicles, including sales managers and F&I personnel.

(b) **Identification card.** A Salesperson's license certificate of registration shall consist of an identification card. The card shall be carried upon his or her person when acting as a Salesperson.

(c) **Termination of employment.** Upon termination of employment of a licensed registered Salesperson, the dealership must notify the Motor Vehicle Commission in writing within ten days.

(d) **One license registration and employer at a time.** No Salesperson may hold be registered with more than one license dealer at any one time or be employed by, or sell for, any Dealer other than the Dealer designated on the Salesperson's license certificate of registration, except as follows:

(1) A Salesperson may hold be registered with more than one license dealer only in instances where the salesperson is employed by multiple dealerships which have the same majority ownership;

(2) The A Salespersons' new ——— or ——— renewal license registration application shall ——— reflect ——— all dealerships must be submitted for each dealership which have the same majority ownership for which the Salesperson seeks a Salespersons' license to be registered;

(3) The identification card or cards which are issued in accordance with OAC Title 465:10-3-3(b), shall contain the names of all commonly owned dealerships for which the Salesperson is licensed registered; and,

(4) The Salesperson shall only sell for the dealerships designated on the Salespersons' identification card.

(e) **Change of employment.** ~~A licensed Salesperson shall, on~~ Upon change of employment to another dealership, surrender the Salesperson's License to the new employer, who shall submit the License along with the appropriate Transfer form and fee to the Commission for issuance of a replacement License reflecting the change of employers; the existing certificate of registration shall be invalid. A new application for registration along with the appropriate fee paid by the employing dealer shall be submitted to the Commission. Within ten days of receipt of a completed application and required fee the Commission will issue a certificate of registration for a New Motor Vehicle Salesperson.

465:10-3-5. Renewal of licenses and salesperson registrations

Application Notification for renewal of all licenses and salesperson registrations shall be ~~mailed sent~~ by the Commission to each of its licensees by May 1 of each year and all licensees shall return the completed renewal application applications, along with the proper fees, by June 1 of each year.

465:10-3-6. Compliance with dealer's tag provision

A Salesperson Certificate of Registration issued in accordance with the procedures set forth in 465:10-3 shall be considered "a valid salesman's license issued by the Oklahoma Motor Vehicle Commission" for purposes of 47 O.S. § 1128(A), concerning a licensed salesperson's exemption from the seventy-two hour limit on operating a motor vehicle with a dealer's tag affixed.

[OAR Docket #19-802; filed 10-25-19]

TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM CHAPTER 10. PUBLIC EMPLOYEES RETIREMENT SYSTEM

[OAR Docket #19-784]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. General Provisions

590:10-1-21. Department of Public Safety Chief of Administration [NEW]

590:10-1-22. Retired members-State Department of Education [NEW]

AUTHORITY:

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

ADOPTION:

August 15, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, 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 legislation enacted in 2019 amending the Oklahoma Statutes relating to the Agency.

GIST/ANALYSIS:

The addition of 590:10-1-21 is necessary to comply with Senate Bill 709, amending 47 O.S. Supp. 2018, Section 2-104. This rule clarifies that the rules and laws governing participation in OPERS-administered systems will govern the election made by the Chief of Administration of the Department of Public Safety regarding his or her retirement under this section of law.

The addition of 590:10-1-22 is necessary to comply with House Bill 1246, amending 72 O.S. §17-103. This rule clarifies that the rules and laws governing participation in OPERS-administered systems will govern the retirement election made by retired members of the Oklahoma Teachers Retirement System who become employed by the State Department of Education for the first time on or after November 1, 2019.

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 1. GENERAL PROVISIONS

590:10-1-21. Department of Public Safety Chief of Administration

A person appointed to the position of Chief of Administration of the Department of Public Safety, pursuant to 47 O.S. Supp. 2018, Section 2-104, shall be eligible to participate in the OPERS Defined Benefit Plan or the OPERS Defined Contribution System, whichever is applicable under the laws and rules governing those systems. The election to participate in the Oklahoma Law Enforcement Retirement System or the OPERS-administered systems shall be made in writing within thirty (30) days from such appointment and is irrevocable.

590:10-1-22. Retired members-State Department of Education

A retired member of the Oklahoma Teachers Retirement System who becomes employed by the State Department of Education for the first time on or after November 1, 2019, shall have the option to remain a member of the Oklahoma Teachers Retirement System subject to any applicable post retirement limitations placed on retired members returning to work, or to participate in the OPERS Defined Benefit Plan or the OPERS Defined Contribution System, whichever is applicable under the laws and rules governing those systems. The election to participate in the Oklahoma Teachers Retirement System or the OPERS-administered systems shall be made in writing within

thirty (30) days from the initial date of hire with the State Department of Education and is irrevocable.

[OAR Docket #19-784; filed 10-15-19]

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

[OAR Docket #19-785]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Eligibility and Participation - Applicable to the 401(a) Plan and the 457(b) Plan

Part 1. Eligibility and Participation - Applicable to the 401(a) Plan and the 457(b) Plan

590:40-5-1. Participation in 401(a) plan and 457(b) plan [AMENDED]

AUTHORITY:

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

ADOPTION:

August 15, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, 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 legislation enacted in 2019 amending the Oklahoma Statutes relating to the Agency.

GIST/ANALYSIS:

The amendment to 590:40-5-1(e) is necessary to comply with Senate Bill 709, amending 47 O.S. Supp. 2018, Section 2-104. This amendment clarifies that the rules and laws governing participation in OPERS-administered systems will govern the election made by the Chief of Administration of the Department of Public Safety regarding his or her retirement under this section of law. The amendment to 590:40-5-1(f) is necessary to comply with House Bill 1246, amending 72 O.S. §17-103. This amendment clarifies that the rules and laws governing participation in OPERS-administered systems will govern the retirement election made by retired members of the Oklahoma Teachers Retirement System who become employed by the State Department of Education for the first time on or after November 1, 2019.

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 5. ELIGIBILITY AND PARTICIPATION - APPLICABLE TO THE 401(A) PLAN AND THE 457(B) PLAN

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PART 1. ELIGIBILITY AND PARTICIPATION - APPLICABLE TO THE 401(A) PLAN AND THE 457(B) PLAN

590:40-5-1. Participation in 401(a) plan and 457(b) plan

(a) **Eligibility.** Each Employee shall become a Participant on the first day of the month following the date of employment with an Employer for the mandatory contributions as set forth in 74 O.S. §935.5 and 590:40-5-5. Participants may participate in voluntary deferrals to the 457(b) plan set forth in 74 O.S. §935.5 and 590:40-5-6 beginning the first day of the month following the entry date of employment. An Employee shall participate in the DC System if the Employee is employed in a full-time-equivalent position or any position which is less than full-time but more than a half-time position and includes employee benefits such as health insurance and leave time. The determination of whether an Employee is in an employment position which is more than a half-time position shall be made by the Employer and such determination shall be exclusively relied upon by OPERS. Members who have been declared eligible to participate in the DC System, but subsequently fall below the level of eligibility for a new member, shall continue to participate in the System.

(b) **Participation upon reemployment.** A former Participant or former Employee who satisfies the eligibility requirements in this section shall become a Participant in the DC System on the first day of the month following the date of reemployment.

(c) **Change in employment status.** In the event a Participant is no longer a member of an eligible class of Employees and becomes ineligible to participate in the DC System, the individual will participate immediately upon returning to an eligible class of Employees.

(d) **Previous participation in defined benefit plan.** Any employee first employed by an Employer prior to November 1, 2015, and was a participating member in OPERS defined benefit plan set forth in 74 O.S. §§ 901 et seq. shall not be a Participant in the DC System. Such employees shall participate in OPERS defined benefit plan set forth in 74 O.S. §§ 901 et seq. regardless of whether the individual maintained membership in the OPERS defined benefit plan. If an employee is first employed by an Employer on or after November 1, 2015, in a position in which the employee is eligible to participate in OPERS defined benefit plan, and such employee subsequently terminates service with such Employer and becomes employed in a position which is eligible under the DC System, the employee shall no longer participate in OPERS defined benefit plan but shall participate in the DC System.

(e) **Department of Public Safety Chief of Administration.** A person appointed to the position of Chief of Administration of the Department of Public Safety, pursuant to 47 O.S. Supp. 2018, Section 2-104, shall be eligible to participate in the OPERS Defined Benefit Plan or the OPERS Defined Contribution System, whichever is applicable under the laws and rules governing those systems. The election to participate in the Oklahoma Law Enforcement Retirement System or the

OPERS-administered systems shall be made in writing within thirty (30) days from such appointment and is irrevocable.

(f) **Retired Members-State Department of Education.** A retired member of the Oklahoma Teachers Retirement System who becomes employed by the State Department of Education for the first time on or after November 1, 2019, shall have the option to remain a member of the Oklahoma Teachers Retirement System subject to any applicable post retirement limitations placed on retired members returning to work, or to participate in the OPERS Defined Benefit Plan or the OPERS Defined Contribution System, whichever is applicable under the laws and rules governing those systems. The election to participate in the Oklahoma Teachers Retirement System or the OPERS-administered systems shall be made in writing within thirty (30) days from the initial date of hire with the State Department of Education and is irrevocable.

[OAR Docket #19-785; filed 10-15-19]

TITLE 765. OKLAHOMA USED MOTOR VEHICLE AND PARTS COMMISSION CHAPTER 15. USED MOTOR VEHICLE SALESPERSONS

[OAR Docket #19-787]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. ~~Licensing~~ Certificate of Registration Qualifications, Procedures and Fees

765:15-1-1 [AMENDED]

765:15-1-2 [AMENDED]

765:15-1-3 [AMENDED]

765:15-1-5 [AMENDED]

765:15-1-6 [AMENDED]

765:15-1-7 [AMENDED]

Subchapter 3. Authority of Salespersons

765:15-3-1 [AMENDED]

Subchapter 5. Assessment of Fine or Denial, Suspension, or Revocation of ~~License~~ Certificate of Registration

765:15-5-1 [AMENDED]

765:15-5-2 [AMENDED]

AUTHORITY:

Oklahoma Used Motor Vehicle and Parts Commission

47 O.S. Section 582(E)(1)

47 O.S. Section 583 B.3.

75 O.S. Section 302 et.seq.

PUBLIC HEARING:

September 10, 2019

ADOPTION:

September 10, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

HB 1094 was passed by the Legislature and signed by Governor Stitt. The effective date is November 1, 2019. The new law will affect the public health,

safety and welfare; will eliminate conflicts in Rules with the new law, thereby avoiding violation of the new law.

GIST/ANALYSIS:

The Rules adopt a regulatory scheme for salespersons consist with HB 1094 and the protection of the public from unqualified applicants or certificate holders.

CONTACT PERSON:

John W. Maile, Executive Director (405)521-3600

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

SUBCHAPTER 1. LICENSING CERTIFICATE OF REGISTRATION QUALIFICATIONS, PROCEDURES AND FEES

765:15-1-1. Purpose

The rules of this Chapter have been adopted for the purpose of complying with the provisions of 75 O.S. Section 250 et seq. and 47 O.S. Section 582 (E). This Chapter will provide a description of the qualifications for obtaining a used motor vehicle salesperson's license certificate of registration, authority of a salesperson, and the grounds and procedure for assessment of a fine or denial, suspension, or revocation of a used motor vehicle salesperson's license certificate of registration.

765:15-1-2. Fees

The fees required for an application or renewal of used motor vehicle salesperson's license certificate of registration are recited in 47 O.S. Section 583.1. A fee will be returned to the applicant in the event the license certificate of registration is denied.

765:15-1-3. Applicant

(a) **Activities requiring license certificate of registration.** A used motor vehicle salesperson is anyone who:

- (1) receives gain or compensation of any kind, directly or indirectly, regularly or occasionally for, or negotiates for, sale or trade of a specified used motor vehicle for a specified used motor vehicle dealer, or
- (2) operates as a broker only for a specified used motor vehicle dealer, or
- (3) receives compensation for referral of a prospective buyer to his employer or acts on behalf of the dealer in the purchase or sale of a used motor vehicle, or
- (4) is authorized to transfer and/or sign titles for the dealership, or
- (5) displays or offers used motor vehicles for sale for the dealership at a licensed location,
- (6) acts in the capacity of sales manager or finance and insurance manager or acts in any capacity as part of the sales process,
- (7) does not otherwise come under the definition of a wholesale used motor vehicle dealer and/or is not

required to obtain a license as a wholesale used motor vehicle dealer, but is authorized by a person licensed by the Oklahoma Motor Vehicle Commission to sell new or unused motor vehicles,(franchise dealer) to purchase and sell used motor vehicles without direct supervision by the "franchise dealer," whether at auction or otherwise, to-wit: a "wholesaler" or individual who pays the "franchise dealer" a draft or check fee for vehicles purchased using the "franchise dealer's" used motor vehicle dealer's license; or who is required to compensate the "franchise dealer" for any loss arising from the sale of a vehicle; or who in any manner operates independently of the ordinary business of the "franchise dealer."

(b) **Information required.** An applicant shall provide sufficient information on the application or otherwise to enable the Commission to determine whether the applicant should be granted a license certificate of registration. The information shall include:

- (1) information relating to the applicant's business integrity, the applicant's experience in the same or similar businesses, and his business history,
- (2) whether the applicant will devote full or part time to the business, and
- (3) any other pertinent information consistent with the safeguarding of the public interest and welfare.

(c) **Application required.** Applications for license certificate of registration shall be verified by the oath or affirmation of the applicant and shall be on forms prescribed by the Commission and furnished to such applicants. The applications shall contain such information as the Commission deems necessary to enable it to fully determine the qualifications and eligibility of the applicant for the license applied for certificate of registration.

(d) **Activity not requiring a license certificate of registration.** A dealer, by written instrument, may authorize another licensed individual or dealer to purchase vehicles for the dealer. Said authorization shall not authorize the individual to conduct any other business for the dealer or represent the dealer in any other manner.

(e) **Activity not authorized.** A salesperson's ~~license certificate of registration~~ shall not authorize the person to refer a prospective customer or consumer to another used motor vehicle dealer and obtain compensation therefor without an employment relationship with the other used motor vehicle dealer.

765:15-1-5. Issuance of license certificate of registration

(a) **Prerequisite.** A license certificate of registration for a used motor vehicle salesperson will not be issued, renewed, or endorsed until the employing dealer is licensed and has certified that the applicant for said license certificate is in his employ. Dealers' payrolls and other evidence will be checked to ascertain that all salespersons for such dealers are licensed registered. ~~It is not intended that the~~ **The dealer shall be required to pay for license certificates of registration for its salespersons. However, the dealer but may do so on a reimbursable basis, or any other plan satisfactory to its dealership**

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organization. All salespersons' ~~licenses~~ certificates of registration will be sent to the dealer for distribution to the respective applicants, and the dealer will determine that all its personnel required to obtain ~~licenses~~ certificates of registration have done so.

(b) **Temporary license certificate of registration.**

(1) A temporary salesperson's license certificate of registration, salesperson's renewal, or reissue of a salesperson's license certificate shall be deemed to have been issued when the appropriate application and fee have been properly addressed and mailed to the Commission, except as follows:

- (A) in the case of incomplete application,
- (B) in the case of proper fee not being submitted,
- (C) in the case of applicant's having been previously denied a license or certificate of registration with this Commission, or
- (D) in the case of applicant's having been convicted of a crime involving moral turpitude (act or behavior that gravely violates accepted moral standards of community), committed any unlawful act which resulted in revocation of similar license in another state, or committed a fraudulent act in selling or purchasing motor vehicles in such a manner as to cause injury to the public.

(2) All temporary salesperson license certificate of registration applications shall be submitted for approval to issue a permanent license certificate of registration at the first monthly Commission meeting following receipt of a completed application.

(c) **Permanent license certificate of registration.** A permanent salesperson's license certificate shall be issued after approval of the applicant by the Commission. A salesperson's ~~license~~ certificate shall consist of an identification card bearing the name, ~~signature of the salesperson,~~ driver's license number, name of employer, address, signature of the Executive Director, and the dealer's license number prefixed with UD (UD-0000). The card shall be carried upon his person at all times when acting as a used motor vehicle salesperson ~~at licensee location.~~

(d) **Reciprocity.** A salesperson's license issued by the Oklahoma Motor Vehicle Commission shall be valid as a used motor vehicle salesperson's license for the dealer's franchised ~~location.~~

765:15-1-6. Renewal of license certificate of registration

All ~~licenses~~ certificates shall expire on the 31st day of December of ~~the odd numbered~~ each year following the date of issue and shall be nontransferable.

765:15-1-7. Changes

(a) **Employer.** If the salesperson changes employer, the license certificate holder shall immediately mail the license certificate of registration to the Commission for its endorsement of the change of employer. ~~There shall be no charge for such endorsement.~~ The licensee holder shall

keep his license certificate on his person while engaged in his business and shall display it upon request; however, there shall be no penalty for not having the license certificate upon his person when he has submitted it to the Commission for its endorsement of a change of employer.

(b) **Notice.** The dealer will notify the Commission in writing when a salesperson's employment is terminated. The dealer may be liable for actions of the salesperson until proper notice is filed with the Commission.

(c) **Salesperson's card.** Each salesperson shall surrender his identification card to the Commission for endorsement of change of employer, before again engaging in the business as a salesperson for another used motor vehicle dealer or as a used motor vehicle dealer.

SUBCHAPTER 3. AUTHORITY OF SALESPERSONS

765:15-3-1. Authority

(a) **Salesperson only.** A used motor vehicle salesperson's license certificate of registration shall permit the licensee holder to engage in the activities of a used motor vehicle salesperson. A salesperson's license certificate does not entitle the licensee holder to perform as a dealer as defined in 47 O.S. Section 581 (4). A used motor vehicle salesperson's license does not entitle a person to separately own vehicles for sale or any interest in the vehicles or dealer business without first qualifying as a partner, corporate member, or part owner of the dealership and meeting the qualifications of a dealer as prescribed in 47 O.S. Sections 581-583.

(b) **One card only.** A salesperson may not hold more than one used motor vehicle salesperson's license certificate at any one time or be employed by or sell for any dealer other than the dealer and at the address designated on the salesperson's license certificate, with the exception that the licensed dealer has more than one location. Then the licensed dealer and ~~licensee~~ salesperson may sell on each location properly licensed as additional locations.

(c) **Restrictions.** A salesperson's license certificate shall not be issued for an individual who is not actively engaged in the activities of a used motor vehicle salesperson, nor shall it be issued for the purpose of allowing an individual to operate a vehicle with a used motor vehicle dealer's plate for any use not benefitting the dealer's business.

SUBCHAPTER 5. ASSESSMENT OF FINE OR DENIAL, SUSPENSION, OR REVOCATION OF LICENSE CERTIFICATE OF REGISTRATION

765:15-5-1. Grounds

(a) The Commission may deny an application for ~~license~~ certificate of registration, or suspend or revoke a license certificate of registration after it has been granted ~~for any of the reasons listed in 47 O.S. Sections 584 (1) through~~

(9) for violation of any statute or regulation relating to the purchase, sale, display for sale, or transfer of a used motor vehicle; or if it is determined that the ~~license~~certificate of registration is being or has been issued for the benefit of a person who would not or could not qualify for the ~~license~~certificate in his or her own right; and;

(b) On satisfactory proof of unfitness of the applicant or the holder of the certificate of registration under the standards established under Title 47 Oklahoma Statutes § 581 et. seq. or the Rules of the Commission,

(c) For fraudulent or material misstatements made by the applicant in any application for license or certificate of registration,

(d) For any willful failure to comply with, or continued or flagrant violation of, any provision of Title 47 Oklahoma Statutes § 581 et. seq. or with any rule promulgated by the Commission,

(e) A change of condition after a certificate is issued resulting in failure to maintain the qualifications for license,

(f) Conviction of a crime involving moral turpitude or any felony which in the opinion of the Commission may have a direct bearing on the ability of the applicant or holder to act as a used motor vehicle salesperson without endangering those with whom the applicant or holder may deal in the conducting of the duties of a used motor vehicle salesperson.

(g) Committing any act within the preceding ten (10) years, which resulted in the revocation of a similar license in another state,

(h) Engaging in business under a past or present license or certificate of registration in such a manner as to cause injury to the public or those with whom the holder is dealing,

(i) For violation of any statute or regulation relating to the purchase, sale, display for sale, or transfer of a used motor vehicle; or if it is determined that the certificate is being or has been issued for the benefit of a person who would not or could not qualify for the certificate in his or her own right.

(bj) The Commission may in addition to any other sanction or penalty assessed, impose a fine as authorized by law

765:15-5-2. Prohibitions

A person whose ~~license~~certificate of registration has been revoked or denied or whose ~~license~~certificate was surrendered in lieu of revocation or under circumstances such that said ~~license~~certificate could have been revoked, shall not have a financial interest of any kind in a used motor vehicle business, nor shall that person participate in any way, including in an advisory position, in the operation of a used motor vehicle business.

[OAR Docket #19-787; filed 10-17-19]

**TITLE 765. OKLAHOMA USED MOTOR VEHICLE AND PARTS COMMISSION
CHAPTER 36. MANUFACTURED HOME MANUFACTURERS**

[OAR Docket #19-788]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 6. Manufactured Home Inspection Fees [NEW]
765:36-6-1 [NEW]

AUTHORITY:

Oklahoma Used Motor Vehicle and Parts Commission
47 O.S. Section 582(E)(1)
47 O.S. Section 583 B.3.
75 O.S. Section 302 et.seq.

PUBLIC HEARING:

September 10, 2019

ADOPTION:

September 10, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

These Emergency Rules relate to the assessment and collection of inspection fees. As such they are necessary to avoid an imminent reduction to the agency's budget which would occur as of the effective date of SB716. If there were no procedure to collect the fees, inspections of installations of manufactured homes could not be performed which would affect public health, safety & welfare.

GIST/ANALYSIS:

The Rules state when inspection fees will be due, how the fees are paid and the purpose of the fees.

CONTACT PERSON:

John W. Maile, Executive Director (405)521-3600

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 6. MANUFACTURED HOME INSPECTION FEES

765:36-6-1. Manufacturer's Fees

(a) Any manufactured home manufacturer who sells a new manufactured home to be shipped into or sited in the State of Oklahoma shall pay an installation inspection fee to The Commission of Seventy-Five Dollars (\$75.00) for each new single wide manufactured home and One Hundred Twenty Five Dollars (\$125.00) for each new multi floor manufactured home.

(b) The fees to be paid by a manufactured home manufacturer shall be due on the fifteenth (15th) day of the month subsequent to the month in which a home is shipped to a

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manufactured home dealer, or sited in, the State of Oklahoma, whichever comes first.

(c) The fees paid shall be used for the purpose of inspecting installations of new manufactured homes. The inspection may be conducted by a representative of the Used Motor Vehicle and Parts Commission or its designee. The decision to inspect an installation shall be made by Commission staff. The decision to inspect an installation may be made by random selection, pursuant to a complaint received by the Commission, or as part of an audit or review of a particular installer.

(d) A manufactured home manufacturer, dealer, or installer shall co-operate with the Commission's employee or designee as needed to conduct an inspection of an installation for which the manufacturer, dealer, or installer may bear some responsibility for assuring that the installation was properly performed.

(e) Any fees not used for inspection of installations may be used for any other purposes of the Commission, but primarily for the education of manufactured home dealers and installers, investigation of manufactured home complaints and administration of the regulatory laws relating to the manufactured home industry.

[OAR Docket #19-788; filed 10-17-19]

TITLE 765. OKLAHOMA USED MOTOR VEHICLE AND PARTS COMMISSION CHAPTER 37. MANUFACTURED HOME INSTALLERS

[OAR Docket #19-789]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Operation
765:37-5-6 [NEW]

AUTHORITY:

Oklahoma Used Motor Vehicle and Parts Commission
47 O.S. Section 582(E)(1)
47 O.S. Section 583 B.3.
75 O.S. Section 302 et.seq.

PUBLIC HEARING:

September 10, 2019

ADOPTION:

September 10, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

These Emergency Rules relate to the assessment and collection of inspection fees. As such they are necessary to avoid an imminent reduction to the agency's budget which would occur as of the effective date of SB716. If there were no procedure to collect the fees, inspections of installations of manufactured homes could not be performed which would affect public health, safety & welfare.

GIST/ANALYSIS:

The Rules state when inspection fees will be due, how the fees are paid and the purpose of the fees.

CONTACT PERSON:

John W. Maile, Executive Director (405)521-3600

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 5. OPERATION

765:37-5-6. Installer's Fees

(a) A used manufactured home inspection fee of Seventy-Five Dollars (\$75.00) shall be paid by the installer at or before the time of installation of any used manufactured home sited and installed in the State of Oklahoma, but no later than that fifteenth (15th) day of the month subsequent to the month in which the installation is performed.

(b) The fees paid shall be used for the purpose of inspecting installations of used manufactured homes. The inspection may be conducted by a representative of the Used Motor Vehicle and Parts Commission or its designee. The decision to inspect an installation shall be made by Commission staff. The decision to inspect an installation may be made by random selection, pursuant to a complaint received by the Commission, or as part of an audit or review of a particular installer.

(c) A manufactured home dealer or installer shall co-operate with the Commission's employee or designee as needed to conduct an inspection of an installation for which the dealer or installer may bear some responsibility for assuring that the installation was properly performed.

(d) Any fees not used for inspection of installations may be used for any other purposes of the Commission but primarily for the education of manufactured home dealers and installers, investigation of manufactured home complaints and administration of the regulatory laws relating to the manufactured home industry.

[OAR Docket #19-789; filed 10-17-19]

TITLE 765. OKLAHOMA USED MOTOR VEHICLE AND PARTS COMMISSION CHAPTER 38. MANUFACTURED HOME SALESPERSONS

[OAR Docket #19-790]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. ~~Licensing~~Registration Qualifications, Procedures and Fees
765:38-1-1 [AMENDED]
765:38-1-2 [AMENDED]
765:38-1-3 [AMENDED]
765:38-1-4 [AMENDED]

765:38-1-5 [AMENDED]
 765:38-1-6 [AMENDED]
 Subchapter 3. Authority of Salespersons
 765:38-3-1 [AMENDED]
 Subchapter 5. Assessment of Fine or Denial, Suspension, or Revocation of
License Certificate of Registration
 765:38-5-1 [AMENDED]
 765:38-5-2 [AMENDED]

AUTHORITY:

Oklahoma Used Motor Vehicle and Parts Commission
 47 O.S. Section 582(E)(1)
 47 O.S. Section 583 B.3.
 75 O.S. Section 302 et.seq.

PUBLIC HEARING:

September 10, 2019

ADOPTION:

September 10, 2019

EFFECTIVE:

Immediately upon Governor's approval

APPROVED BY GOVERNOR:

October 2, 2019

EXPIRATION:

Effective through September 14, 2020, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

HB 1094 was passed by the Legislature and signed by Governor Stitt. The effective date is November 1, 2019. The new law will affect the public health, safety and welfare, will eliminate conflicts in Rules with the new law, thereby avoiding violation of the new law.

GIST/ANALYSIS:

The Rules adopt a regulatory scheme for salespersons consist with HB 1094 and the protection of the public from unqualified applicants or certificate holders.

CONTACT PERSON:

John W. Maile, Executive Director (405)521-3600

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

SUBCHAPTER 1. LICENSING REGISTRATION QUALIFICATIONS, PROCEDURES AND FEES

765:38-1-1. Purpose

The rules of this Chapter have been adopted for the purpose of complying with the provisions of 75 O.S. Section 250 et seq. and 47 O.S. Section 582 (E). This Chapter will provide a description of the qualifications for obtaining a manufactured home salesperson's license certificate of registration, authority of a salesperson, and the grounds and procedure for assessment of a fine or denial, suspension, or revocation of a manufactured home salesperson's license certificate of registration.

765:38-1-2. Fees

The fees required for an application or renewal of manufactured home salesperson's license certificate of registration are recited in 47 O.S. Section 583.1.

765:38-1-3. Applicant

(a) Activities requiring license certificate of registration.

A manufactured home salesperson is anyone who has been engaged by a manufactured home dealer to buy, sell, exchange, negotiate or act as an agent for the purchase, sale or exchange of an interest in a manufactured home on behalf of the dealer for whom the salesperson is employed. A salesperson shall include anyone employed by the manufactured home dealer who is involved in any part of the sales process, including but not limited to the sales manager and finance and/or insurance manager.

(b) Information required. An applicant shall provide sufficient information on the application or otherwise to enable the Commission to determine whether the applicant should be granted a license certificate of registration. The information shall include:

- (1) information relating to the applicant's business integrity, the applicant's experience in the same or similar businesses, and his business history,
- (2) whether the applicant will devote full or part time to the business, and
- (3) any other pertinent information consistent with the safeguarding of the public interest and welfare.

(c) Application required. Applications for license certificate of registration shall be verified by the oath or affirmation of the applicant and shall be on forms prescribed by the Commission and furnished to such applicants. The applications shall contain such information as the Commission deems necessary to enable it to fully determine the qualifications and eligibility of the applicant for the license certificate of registration applied for.

(d) Activity not authorized. A salesperson's license certificate of registration shall not authorize the person to refer a prospective customer or consumer to another manufactured home dealer and obtain compensation therefor without an employment relationship with the other manufactured home dealer.

765:38-1-4. Issuance of license certificate of registration

(a) Prerequisite. A license certificate of registration for a manufactured home salesperson will not be issued, renewed, or endorsed until the employing dealer is licensed and has certified that the applicant for said license certificate is in his employ. Dealers' payrolls and other evidence will be checked to ascertain that all salespersons for such dealers are licensed registered. ~~It is not intended that the dealer be required to pay for licenses for its salespersons. However, the~~ The dealer shall pay for the certificate of registration, but may do so on a reimbursable basis, or any other plan satisfactory to its dealership organization. All salesperson's licenses certificates of registration will be sent to the dealer for distribution to the respective applicants, and the dealer will determine that all its personnel required to obtain licenses certificates have done so.

(b) Permanent license certificate of registration. A permanent salesperson's license certificate of registration shall be issued after approval of the applicant by the Commission. A salesperson's license certificate shall consist of an identification

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card bearing the name, ~~signature of the salesperson, social security number~~, name of employer, address, signature of the Executive Director, the dealer's license number prefixed with MH, (MH-0000). The card shall be carried upon his person at all times when acting as a manufactured home salesperson at licensee location.

765:38-1-5. Renewal of license certificate of registration

All ~~license certificates~~ shall expire on the 31st day of December, of ~~the odd numbered each~~ year following the date of issue and shall be nontransferable.

765:38-1-6. Changes

(a) **Employer.** If the salesperson changes employer, the ~~license holder~~ of the certificate of issue shall ~~within thirty (30) days of~~ immediately upon employment by another manufactured home dealer, apply for a salesperson's license certificate of registration with the new employer. The salesperson shall surrender his salesperson's license certificate of registration upon termination of the employment relationship.

(b) **Notice.** The dealer will notify the Commission in writing when a salesperson's employment is terminated. The dealer may be liable for actions of the salesperson until proper notice is filed with the Commission.

SUBCHAPTER 3. AUTHORITY OF SALESPERSONS

765:38-3-1. Authority

(a) **Salesperson only.** A manufactured home salesperson's license certificate of registration shall permit the ~~license holder~~ to engage in the activities of a manufactured home salesperson. A salesperson's license certificate of registration does not entitle the ~~license holder~~ to perform as a dealer as defined in 47 O.S. Section 581. A manufactured home salesperson's license certificate of registration does not entitle a person to separately own manufactured homes for sale or any interest in the manufactured homes or dealer business without first qualifying as a partner, corporate member, or part owner of the dealership and meeting the qualifications of a dealer as prescribed in 47 O.S. Sections 581-583.

(b) **One card only.** A salesperson may not hold more than one manufactured home salesperson's license certificate of registration at any one time or be employed by or sell for any dealer other than the dealer and at the address designated on the salesperson's license certificate, with the exception that the licensed dealer has more than one location. Then the licensed dealer and ~~licensed~~ salesperson may sell on each location properly licensed as additional locations.

(c) **Restrictions.** A salesperson's license certificate of registration shall not be issued for an individual who is not actively engaged in the activities of a manufactured home salesperson.

SUBCHAPTER 5. ASSESSMENT OF FINE OR DENIAL, SUSPENSION, OR REVOCATION OF LICENSE CERTIFICATE OF REGISTRATION

765:38-5-1. Grounds

(a) The Commission may deny an application for ~~license certificate of registration~~, or suspend or revoke a ~~license certificate~~ after it has been granted for ~~any of the reasons listed in 47 O.S. Sections 584 (1) through (6);~~ for violation of any statute or regulation relating to the purchase, sale, display for sale, or transfer of a manufactured home; or if it is determined that the license is being or has been issued for the benefit of a person who would not or could not qualify for the license in his or her own right ~~and;~~

(b) On satisfactory proof of unfitness of the applicant or the holder of the certificate of registration under the standards established under Title 47 Oklahoma Statutes § 581 et seq. or the Rules of the Commission.

(c) For fraudulent or material misstatements made by the applicant in any application for license or certificate of registration.

(d) For any willful failure to comply with, or continued or flagrant violation of, any provision of Title 47 Oklahoma Statutes § 581 et. seq. or with any rule promulgated by the Commission.

(e) A change of condition after a certificate issued resulting in failure to maintain the qualifications for license.

(f) Conviction of a crime involving moral turpitude or any felony which in the opinion of the Commission may have a direct bearing on the ability of the applicant or holder to act as a used motor vehicle salesperson without endangering those with whom the applicant or holder may deal in the conducting of the duties of a manufactured home salesperson.

(g) Committing any act within the preceding ten (10) years, which resulted in the revocation of a similar license in another state.

(h) Engaging in business under a past or present license or certificate of registration in such a manner as to cause injury to the public or those with whom the holder is dealing, or:

(i) For violation of any statute or regulation relating the purchase, sale, display for sale, or transfer of a manufactured home; or if it is determined that the certificate is being or has been issued for the benefit of a person who would not or could not qualify for the certificate in his or her own right.

(j) The Commission may in addition to any other sanction or penalty assessed, impose a fine as authorized by law.

765:38-5-2. Prohibitions

A person whose license certificate of registration has been revoked or denied or whose license certificate was surrendered in lieu of revocation or under circumstances such that said license certificate of registration could have been revoked, shall not have a financial interest of any kind in a manufactured home sales business, nor shall that person participate in any

way, including in an advisory position, in the operation of a manufactured home sales business.

[OAR Docket #19-790; filed 10-17-19]

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

1:2019-42.

EXECUTIVE ORDER 2019-42

I, J. Kevin Stitt, Governor of the State of Oklahoma, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. to 5:00 p.m., on Friday, November 1, 2019, as a mark of respect for the memory and longstanding service of former Oklahoma State Senator Roger Ballenger, whose funeral service and interment will take place in Okmulgee, Oklahoma.

Former Senator Ballenger represented the residents of Oklahoma Senate District 8 with integrity. He was a concerned legislator who worked diligently on public safety and veteran issues. Former Senator Ballenger has a long record of service to our state and nation. He served in the United States Navy during the Vietnam War (1969-1973), as a former Okmulgee city councilmember, Okmulgee County Commissioner, Oklahoma State Senator and Okmulgee city manager.

This executive order shall be forwarded to the Division of Capital Assets Management, who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, on this 31st day of October, 2019

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

J. Kevin Stitt

ATTEST:
Michael Rogers
Secretary of State

[OAR Docket #19-805; filed 10-31-19]

