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Office of Administrative Rules



**Brad Henry, Governor**  
**M. Susan Savage,**  
**Secretary of State**  
**Peggy Coe, Editor-in-Chief**

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# Table of Contents

<b>Agency/Action/Subject Index</b> .....	iii
<b>Rules Affected Index</b> .....	iv
<b>Agency Index (Title numbers assigned)</b> .....	vi
<b>Notices of Rulemaking Intent</b>	
Health, Oklahoma State Department of (Title 310) .....	109, 110
Horse Racing Commission, Oklahoma (Title 325) .....	111
Real Estate Appraiser Board (Title 600) .....	111, 112
Teacher Preparation, Oklahoma Commission for (Title 712) .....	113
Water Resources Board, Oklahoma (Title 785) .....	113, 114, 115, 116
<b>Emergency Adoptions</b>	
Agriculture, Food, and Forestry, Oklahoma Department of (Title 35) .....	119, 120
Election Board, State (Title 230) .....	120
Health Care Authority, Oklahoma (Title 317) .....	123, 126, 127, 148
Personnel Management, Office of (Title 530) .....	168
<b>Executive Orders (Title 1)</b> .....	171



# Agency/Action/Subject Index

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

*Emergency Adoptions*

- Animal Industry (Chapter 15) ..... 119
- Food Safety (Chapter 37) ..... 120

**ELECTION Board, State (Title 230)**

*Emergency Adoptions*

- Absentee Voting (Chapter 30) ..... 120

**GOVERNOR**

*Executive Orders*

- Ordering flags at half-staff to honor Justice Marian P. Opala  
(10-45) ..... 171

**HEALTH, Oklahoma State Department of (Title 310)**

*Notices of Rulemaking Intent*

- Care of Eyes for Newborn Children [REVOKED]  
(Chapter 510) ..... 109
- Home Care Agencies (Chapter 662) ..... 110

**HEALTH Care Authority, Oklahoma (Title 317)**

*Emergency Adoptions*

- Medical Providers-Fee for Service (Chapter 30) ..... 123
- Insure Oklahoma/~~Oklahoma Employer and Employee  
Partnership for Insurance Coverage~~ (Chapter 45) ..... 126
- Home and Community Based Services Waivers  
(Chapter 50) ..... 127, 148

**HORSE Racing Commission, Oklahoma (Title 325)**

*Notices of Rulemaking Intent*

- Entries and Declarations (Chapter 25) ..... 111

**PERSONNEL Management, Office of (Title 530)**

*Emergency Adoptions*

- Merit System of Personnel Administration Rules  
(Chapter 10) ..... 168

**REAL Estate Appraiser Board (Title 600)**

*Notices of Rulemaking Intent*

- Appraisal Management Company Registration  
(Chapter 30) ..... 111
- Appraisal Management Company Enforcement  
(Chapter 35) ..... 112

**TEACHER Preparation, Oklahoma Commission for  
(Title 712)**

*Notices of Rulemaking Intent*

- Teacher Preparation Program Accreditation  
(Chapter 10) ..... 113

**WATER Resources Board, Oklahoma (Title 785)**

*Notices of Rulemaking Intent*

- Well Driller and Pump Installer Licensing (Chapter 35) ... 113
- Oklahoma's Water Quality Standards (Chapter 45) ..... 114
- Implementation of Oklahoma's Water Quality Standards  
(Chapter 46) ..... 115
- Financial Assistance (Chapter 50) ..... 116

# Rules Affected Index

[(E) = Emergency action]

Rule	Register Page	Rule	Register Page
25:30-1-1.....	[NEW] (E) ..... 77	252:220-11-4.....	[REVOKED] (E) ..... 87
25:30-1-2.....	[NEW] (E) ..... 77	252:220-11-5.....	[REVOKED] (E) ..... 88
25:30-1-3.....	[NEW] (E) ..... 78	252:220-11-6.....	[REVOKED] (E) ..... 88
25:30-1-4.....	[NEW] (E) ..... 78	252:220-11-7.....	[REVOKED] (E) ..... 88
25:30-1-5.....	[NEW] (E) ..... 79	252:220-11-8.....	[REVOKED] (E) ..... 88
25:30-3-1.....	[NEW] (E) ..... 79	252:220-11-9.....	[REVOKED] (E) ..... 88
25:30-3-2.....	[NEW] (E) ..... 79	252:220-11-10.....	[REVOKED] (E) ..... 88
25:30-3-3.....	[NEW] (E) ..... 79	252:221-1-1.....	[NEW] (E) ..... 89
25:30-3-4.....	[NEW] (E) ..... 79	252:221-1-2.....	[NEW] (E) ..... 90
25:30-5-1.....	[NEW] (E) ..... 80	252:221-1-3.....	[NEW] (E) ..... 90
25:30-5-2.....	[NEW] (E) ..... 80	252:221-1-4.....	[NEW] (E) ..... 90
25:30-7-1.....	[NEW] (E) ..... 80	252:221-1-5.....	[NEW] (E) ..... 90
25:30-7-2.....	[NEW] (E) ..... 80	252:221-1-6.....	[NEW] (E) ..... 90
25:30-7-3.....	[NEW] (E) ..... 80	252:221-1-7.....	[NEW] (E) ..... 90
25:30-7-4.....	[NEW] (E) ..... 81	252:221-1-8.....	[NEW] (E) ..... 90
25:30-7-5.....	[NEW] (E) ..... 81	252:221-3-1.....	[NEW] (E) ..... 90
25:30-7-6.....	[NEW] (E) ..... 81	252:221-3-2.....	[NEW] (E) ..... 90
25:30-9-1.....	[NEW] (E) ..... 81	252:221-3-3.....	[NEW] (E) ..... 91
25:30-9-2.....	[NEW] (E) ..... 81	252:221-3-4.....	[NEW] (E) ..... 91
25:30-9-3.....	[NEW] (E) ..... 81	252:221-3-5.....	[NEW] (E) ..... 91
25:30-11-1.....	[NEW] (E) ..... 81	252:221-3-6.....	[NEW] (E) ..... 92
25:30, App. A.....	[NEW] (E) ..... 83	252:221-3-7.....	[NEW] (E) ..... 92
35:15-22-33.....	[AMENDED] (E) ..... 119	252:221-3-8.....	[NEW] (E) ..... 92
35:37-13-7.....	[NEW] (E) ..... 120	252:221-3-9.....	[NEW] (E) ..... 92
160:5-1-2.....	[AMENDED] (E) ..... 63	252:221-3-10.....	[NEW] (E) ..... 92
230:30-13-1.....	[AMENDED] (E) ..... 121	252:221-3-11.....	[NEW] (E) ..... 92
230:30-13-3.....	[AMENDED] (E) ..... 121	252:221-3-12.....	[NEW] (E) ..... 92
230:30-15-1.....	[AMENDED] (E) ..... 121	252:221-5-1.....	[NEW] (E) ..... 92
230:30-15-3.....	[AMENDED] (E) ..... 121	252:221-5-2.....	[NEW] (E) ..... 93
230:30-15-4.....	[AMENDED] (E) ..... 122	252:221-7-1.....	[NEW] (E) ..... 93
230:30-15-5.....	[AMENDED] (E) ..... 122	252:221-7-2.....	[NEW] (E) ..... 93
230:30-15-6.....	[AMENDED] (E) ..... 122	252:221-7-3.....	[NEW] (E) ..... 93
230:30-15-7.....	[AMENDED] (E) ..... 122	252:221-7-4.....	[NEW] (E) ..... 93
230:30-15-9.....	[AMENDED] (E) ..... 122	252:221-7-5.....	[NEW] (E) ..... 93
252:4-7-61.....	[REVOKED] (E) ..... 84	252:221-7-6.....	[NEW] (E) ..... 94
252:4-7-62.....	[REVOKED] (E) ..... 84	252:221-7-7.....	[NEW] (E) ..... 94
252:4-7-63.....	[REVOKED] (E) ..... 84	252:221-7-8.....	[NEW] (E) ..... 94
252:220-1-1.....	[REVOKED] (E) ..... 85	252:221-7-9.....	[NEW] (E) ..... 94
252:220-1-2.....	[REVOKED] (E) ..... 85	252:221-7-10.....	[NEW] (E) ..... 95
252:220-1-3.....	[REVOKED] (E) ..... 85	252:221-7-11.....	[NEW] (E) ..... 95
252:220-1-4.....	[REVOKED] (E) ..... 85	252:221-7-12.....	[NEW] (E) ..... 95
252:220-1-5.....	[REVOKED] (E) ..... 85	252:221-7-13.....	[NEW] (E) ..... 95
252:220-3-1.....	[REVOKED] (E) ..... 85	317:2-1-2.....	[AMENDED] (E) ..... 7
252:220-3-2.....	[REVOKED] (E) ..... 85	317:25-7-7.....	[NEW] (E) ..... 9
252:220-5-1.....	[REVOKED] (E) ..... 85	317:30-3-5.....	[AMENDED] (E) ..... 10
252:220-5-2.....	[AMENDED] (E) ..... 86	317:30-5-211.5.....	[AMENDED] (E) ..... 11
252:220-5-3.....	[REVOKED] (E) ..... 86	317:30-5-293.....	[NEW] (E) ..... 13
252:220-5-4.....	[REVOKED] (E) ..... 86	317:30-5-299.....	[NEW] (E) ..... 13
252:220-5-5.....	[REVOKED] (E) ..... 86	317:30-5-555.....	[AMENDED] (E) ..... 14
252:220-5-6.....	[REVOKED] (E) ..... 86	317:30-5-556.....	[AMENDED] (E) ..... 14
252:220-5-7.....	[REVOKED] (E) ..... 86	317:30-5-557.....	[AMENDED] (E) ..... 14
252:220-5-8.....	[REVOKED] (E) ..... 86	317:30-5-558.....	[AMENDED] (E) ..... 15
252:220-5-9.....	[REVOKED] (E) ..... 86	317:30-5-559.....	[AMENDED] (E) ..... 15
252:220-7-1.....	[REVOKED] (E) ..... 86	317:30-5-560.....	[AMENDED] (E) ..... 15
252:220-7-2.....	[REVOKED] (E) ..... 86	317:30-5-560.1.....	[AMENDED] (E) ..... 15
252:220-7-3.....	[REVOKED] (E) ..... 86	317:30-5-660.1.....	[AMENDED] (E) ..... 123
252:220-9-1.....	[REVOKED] (E) ..... 86	317:30-5-660.3.....	[AMENDED] (E) ..... 123
252:220-9-2.....	[REVOKED] (E) ..... 86	317:30-5-660.4.....	[AMENDED] (E) ..... 124
252:220-11-1.....	[REVOKED] (E) ..... 87	317:30-5-661.1.....	[AMENDED] (E) ..... 124
252:220-11-2.....	[REVOKED] (E) ..... 87	317:30-5-661.5.....	[AMENDED] (E) ..... 124
252:220-11-3.....	[REVOKED] (E) ..... 87	317:30-5-661.7.....	[AMENDED] (E) ..... 124

317:30-5-664.5. . . . .	[AMENDED] (E) . . . . .	125	590:10-21-3. . . . .	[NEW] (E) . . . . .	98
317:30-5-664.7. . . . .	[AMENDED] (E) . . . . .	125	590:10-21-4. . . . .	[NEW] (E) . . . . .	98
317:30-5-664.10. . . . .	[AMENDED] (E) . . . . .	126	590:10-21-5. . . . .	[NEW] (E) . . . . .	98
317:30-5-664.11. . . . .	[REVOKED] (E) . . . . .	126	590:10-21-6. . . . .	[NEW] (E) . . . . .	98
317:30-5-680. . . . .	[NEW] (E) . . . . .	13	590:10-21-7. . . . .	[NEW] (E) . . . . .	99
317:30-5-1091. . . . .	[AMENDED] (E) . . . . .	16	590:10-21-8. . . . .	[NEW] (E) . . . . .	99
317:30-5-1098. . . . .	[AMENDED] (E) . . . . .	17	590:10-21-9. . . . .	[NEW] (E) . . . . .	100
317:45-13-1. . . . .	[NEW] (E) . . . . .	127	590:10-21-10. . . . .	[NEW] (E) . . . . .	100
317:50-3-1. . . . .	[NEW] (E) . . . . .	127	590:10-21-11. . . . .	[NEW] (E) . . . . .	100
317:50-3-2. . . . .	[NEW] (E) . . . . .	127	590:10-21-12. . . . .	[NEW] (E) . . . . .	100
317:50-3-3. . . . .	[NEW] (E) . . . . .	129	590:10-21-13. . . . .	[NEW] (E) . . . . .	100
317:50-3-4. . . . .	[NEW] (E) . . . . .	131	590:15-5-1. . . . .	[NEW] (E) . . . . .	101
317:50-3-5. . . . .	[NEW] (E) . . . . .	131	590:15-5-2. . . . .	[NEW] (E) . . . . .	101
317:50-3-6. . . . .	[NEW] (E) . . . . .	132	590:15-5-3. . . . .	[NEW] (E) . . . . .	102
317:50-3-7. . . . .	[NEW] (E) . . . . .	137	590:15-5-4. . . . .	[NEW] (E) . . . . .	102
317:50-3-8. . . . .	[NEW] (E) . . . . .	137	590:15-5-5. . . . .	[NEW] (E) . . . . .	102
317:50-3-9. . . . .	[NEW] (E) . . . . .	137	590:15-5-6. . . . .	[NEW] (E) . . . . .	102
317:50-3-10. . . . .	[NEW] (E) . . . . .	138	590:15-5-7. . . . .	[NEW] (E) . . . . .	102
317:50-3-11. . . . .	[NEW] (E) . . . . .	138	590:15-5-8. . . . .	[NEW] (E) . . . . .	103
317:50-3-12. . . . .	[NEW] (E) . . . . .	138	590:15-5-9. . . . .	[NEW] (E) . . . . .	103
317:50-3-13. . . . .	[NEW] (E) . . . . .	140	590:15-5-10. . . . .	[NEW] (E) . . . . .	103
317:50-3-14. . . . .	[NEW] (E) . . . . .	140	590:15-5-11. . . . .	[NEW] (E) . . . . .	103
317:50-3-15. . . . .	[NEW] (E) . . . . .	147	590:15-5-12. . . . .	[NEW] (E) . . . . .	103
317:50-3-16. . . . .	[NEW] (E) . . . . .	148	590:15-5-13. . . . .	[NEW] (E) . . . . .	104
317:50-5-1. . . . .	[NEW] (E) . . . . .	148	710:50-15-74. . . . .	[AMENDED] (E) . . . . .	18
317:50-5-2. . . . .	[NEW] (E) . . . . .	148	710:50-15-76. . . . .	[AMENDED] (E) . . . . .	20
317:50-5-3. . . . .	[NEW] (E) . . . . .	150	710:50-15-81. . . . .	[AMENDED] (E) . . . . .	21
317:50-5-4. . . . .	[NEW] (E) . . . . .	151	710:50-15-84. . . . .	[AMENDED] (E) . . . . .	21
317:50-5-5. . . . .	[NEW] (E) . . . . .	152	710:50-15-85. . . . .	[AMENDED] (E) . . . . .	21
317:50-5-6. . . . .	[NEW] (E) . . . . .	152	710:50-15-86. . . . .	[AMENDED] (E) . . . . .	22
317:50-5-7. . . . .	[NEW] (E) . . . . .	158	710:50-15-87. . . . .	[AMENDED] (E) . . . . .	24
317:50-5-8. . . . .	[NEW] (E) . . . . .	158	710:50-15-91. . . . .	[AMENDED] (E) . . . . .	25
317:50-5-9. . . . .	[NEW] (E) . . . . .	158	710:50-15-92. . . . .	[AMENDED] (E) . . . . .	25
317:50-5-10. . . . .	[NEW] (E) . . . . .	159	710:50-15-95. . . . .	[AMENDED] (E) . . . . .	26
317:50-5-11. . . . .	[NEW] (E) . . . . .	159	710:50-15-97. . . . .	[AMENDED] (E) . . . . .	26
317:50-5-12. . . . .	[NEW] (E) . . . . .	159	710:50-15-98. . . . .	[AMENDED] (E) . . . . .	27
317:50-5-13. . . . .	[NEW] (E) . . . . .	160	710:50-15-99. . . . .	[AMENDED] (E) . . . . .	28
317:50-5-14. . . . .	[NEW] (E) . . . . .	160	710:50-15-101. . . . .	[AMENDED] (E) . . . . .	28
317:50-5-15. . . . .	[NEW] (E) . . . . .	168	710:50-15-103. . . . .	[AMENDED] (E) . . . . .	29
317:50-5-16. . . . .	[NEW] (E) . . . . .	168	710:50-15-104. . . . .	[AMENDED] (E) . . . . .	30
340:25-5-351. . . . .	[AMENDED] (E) . . . . .	49	710:50-15-105. . . . .	[AMENDED] (E) . . . . .	31
340:100-18-1. . . . .	[NEW] (E) . . . . .	51	710:50-15-106. . . . .	[AMENDED] (E) . . . . .	31
530:10-13-3. . . . .	[AMENDED] (E) . . . . .	169	710:50-15-107. . . . .	[AMENDED] (E) . . . . .	32
530:10-13-12. . . . .	[AMENDED] (E) . . . . .	169	710:50-15-108. . . . .	[AMENDED] (E) . . . . .	33
530:10-13-32. . . . .	[AMENDED] (E) . . . . .	169	710:50-15-109. . . . .	[AMENDED] (E) . . . . .	34
590:10-3-13. . . . .	[AMENDED] (E) . . . . .	96	710:50-15-110. . . . .	[NEW] (E) . . . . .	35
590:10-7-18. . . . .	[AMENDED] (E) . . . . .	96	710:65-21-8. . . . .	[NEW] (E) . . . . .	104
590:10-9-2. . . . .	[AMENDED] (E) . . . . .	97	775:10-11-1. . . . .	[NEW] (E) . . . . .	37
590:10-17-10. . . . .	[NEW] (E) . . . . .	97	775:10-12-1. . . . .	[NEW] (E) . . . . .	37
590:10-21-1. . . . .	[NEW] (E) . . . . .	97	775:10-12-2. . . . .	[NEW] (E) . . . . .	54
590:10-21-2. . . . .	[NEW] (E) . . . . .	98	775:10-12-3. . . . .	[NEW] (E) . . . . .	54

# Agency/Title Index

[Assigned as of 11-15-10]

Agency	Title	Agency	Title
Oklahoma <b>ABSTRACTORS</b> Board	5	<b>EDGE</b> Fund Policy Board	208
Oklahoma <b>ACCOUNTANCY</b> Board	10	State Department of <b>EDUCATION</b>	210
State <b>ACCREDITING</b> Agency	15	<b>EDUCATION</b> Oversight Board	215
<b>AD Valorem</b> Task Force ( <i>abolished 7-1-93</i> )	20	Oklahoma <b>EDUCATIONAL</b> Television Authority	220
Oklahoma <b>AERONAUTICS</b> Commission	25	[RESERVED]	225
Board of Regents for the Oklahoma <b>AGRICULTURAL</b> and Mechanical Colleges ( <i>exempted 11-1-98</i> )	30	State <b>ELECTION</b> Board	230
Oklahoma Department of <b>AGRICULTURE</b> , Food, and Forestry	35	Oklahoma <b>FUNERAL</b> Board ( <i>Formerly</i> : Oklahoma State Board of <b>EMBALMERS</b> and Funeral Directors)	235
Oklahoma Board of Licensed <b>ALCOHOL</b> and Drug Counselors	38	Oklahoma Department of <b>EMERGENCY</b> Management ( <i>Formerly</i> : Department of <b>CIVIL</b> Emergency Management) - <i>See</i> Title 145	
Board of Tests for <b>ALCOHOL</b> and Drug Influence	40	Oklahoma <b>EMPLOYMENT</b> Security Commission	240
<b>ALCOHOLIC</b> Beverage Laws Enforcement Commission	45	Oklahoma <b>ENERGY</b> Resources Board	243
<b>ANATOMICAL</b> Board of the State of Oklahoma	50	State Board of Licensure for Professional <b>ENGINEERS</b> and Land Surveyors ( <i>Formerly</i> : State Board of Registration for Professional <b>ENGINEERS</b> and Land Surveyors)	245
Board of Governors of the Licensed <b>ARCHITECTS</b> , Landscape Architects and Registered Interior Designers of Oklahoma ( <i>Formerly</i> : Board of Governors of the Licensed <b>ARCHITECTS</b> and Landscape Architects of Oklahoma; and Board of Governors of the Licensed <b>ARCHITECTS</b> , Landscape Architects and Interior Designers of Oklahoma)	55	Board of Trustees for the <b>ENID</b> Higher Education Program ( <i>exempted 11-1-98</i> )	250
<b>ARCHIVES</b> and Records Commission	60	Department of <b>ENVIRONMENTAL</b> Quality	252
Board of Trustees for the <b>ARDMORE</b> Higher Education Program ( <i>exempted 11-1-98</i> )	65	State Board of <b>EQUALIZATION</b>	255
Oklahoma <b>ARTS</b> Council	70	<b>ETHICS</b> Commission ( <i>Title revoked</i> )	257
Oklahoma State <b>ATHLETIC</b> Commission ( <i>Formerly</i> : Oklahoma Professional <b>BOXING</b> Commission) - <i>See</i> Title 92		<b>ETHICS</b> Commission	258
<b>ATTORNEY</b> General	75	Office of State <b>FINANCE</b>	260
State <b>AUDITOR</b> and Inspector	80	State <b>FIRE</b> Marshal Commission	265
State <b>BANKING</b> Department	85	Oklahoma Council on <b>FIREFIGHTER</b> Training	268
Oklahoma State Employees <b>BENEFITS</b> Council	87	Oklahoma <b>FIREFIGHTERS</b> Pension and Retirement System	270
Council of <b>BOND</b> Oversight	90	[RESERVED]	275
Oklahoma State <b>ATHLETIC</b> Commission ( <i>Formerly</i> : Oklahoma Professional <b>BOXING</b> Commission)	92	<b>FORENSIC</b> Review Board	277
State <b>BURIAL</b> Board ( <i>abolished 7-1-92</i> )	95	State Board of Registration for <b>FORESTERS</b>	280
[RESERVED]	100	<b>FOSTER</b> Care Review Advisory Board	285
Oklahoma <b>CAPITAL</b> Investment Board	105	Oklahoma <b>FUNERAL</b> Board ( <i>Formerly</i> : Oklahoma State Board of Embalmers and Funeral Directors) - <i>See</i> Title 235	
Oklahoma <b>CAPITOL</b> Improvement Authority	110	Oklahoma <b>FUTURES</b>	290
State <b>CAPITOL</b> Preservation Commission	115	<b>GOVERNOR</b> ( <i>See also</i> Title 1, Executive Orders)	295
<b>CAPITOL-MEDICAL</b> Center Improvement and Zoning Commission	120	<b>GRAND</b> River Dam Authority	300
Oklahoma Department of <b>CAREER</b> and Technology Education ( <i>Formerly</i> : Oklahoma Department of <b>VOCATIONAL</b> and Technical Education) - <i>See</i> Title 780		Group Self-Insurance Association <b>GUARANTY</b> Fund Board	302
Board of Regents of <b>CARL</b> Albert State College ( <i>exempted 11-1-98</i> )	125	Individual Self-Insured <b>GUARANTY</b> Fund Board	303
Department of <b>CENTRAL</b> Services ( <i>Formerly</i> : Office of <b>PUBLIC</b> Affairs) - <i>See</i> Title 580		<b>STATE</b> Use Committee ( <i>Formerly</i> : Committee on Purchases of Products and Services of the Severely <b>HANDICAPPED</b> )	304
<b>CEREBRAL</b> Palsy Commission	130	Office of <b>DISABILITY</b> Concerns ( <i>Formerly</i> : Office of <b>HANDICAPPED</b> Concerns)	305
Commission on <b>CHILDREN</b> and Youth	135	Oklahoma State Department of <b>HEALTH</b>	310
Board of <b>CHIROPRACTIC</b> Examiners	140	Oklahoma Basic <b>HEALTH</b> Benefits Board ( <i>abolished 11-1-97</i> )	315
Oklahoma Department of <b>EMERGENCY</b> Management ( <i>Formerly</i> : Department of <b>CIVIL</b> Emergency Management)	145	Oklahoma <b>HEALTH</b> Care Authority	317
Oklahoma Department of <b>COMMERCE</b>	150	<b>HIGHWAY</b> Construction Materials Technician Certification Board	318
<b>COMMUNITY</b> Hospitals Authority	152	Oklahoma <b>HISTORICAL</b> Society	320
<b>COMPSOURCE</b> Oklahoma ( <i>Formerly</i> : State <b>INSURANCE</b> Fund) - <i>See</i> Title 370		Oklahoma <b>HORSE</b> Racing Commission	325
Oklahoma <b>CONSERVATION</b> Commission	155	Oklahoma <b>HOUSING</b> Finance Agency	330
<b>CONSTRUCTION</b> Industries Board	158	Oklahoma <b>HUMAN</b> Rights Commission	335
Department of <b>CONSUMER</b> Credit	160	Department of <b>HUMAN</b> Services	340
<b>CORPORATION</b> Commission	165	Committee for <b>INCENTIVE</b> Awards for State Employees	345
Department of <b>CORRECTIONS</b>	170	Oklahoma <b>INDIAN</b> Affairs Commission	350
State Board of <b>COSMETOLOGY</b>	175	Oklahoma <b>INDIGENT</b> Defense System	352
Oklahoma State <b>CREDIT</b> Union Board	180	Oklahoma <b>INDUSTRIAL</b> Finance Authority	355
<b>CRIME</b> Victims Compensation Board	185	<b>INJURY</b> Review Board	357
Joint <b>CRIMINAL</b> Justice System Task Force Committee	190	Oklahoma State and Education Employees Group <b>INSURANCE</b> Board	360
Board of <b>DENTISTRY</b>	195	<b>INSURANCE</b> Department	365
Oklahoma <b>DEVELOPMENT</b> Finance Authority	200	<b>COMPSOURCE</b> Oklahoma ( <i>Formerly</i> : State <b>INSURANCE</b> Fund)	370
Office of <b>DISABILITY</b> Concerns ( <i>Formerly</i> : Office of <b>HANDICAPPED</b> Concerns) - <i>See</i> Title 305		Oklahoma State Bureau of <b>INVESTIGATION</b>	375
Board of Regents of <b>EASTERN</b> Oklahoma State College ( <i>exempted 11-1-98</i> )	205	Council on <b>JUDICIAL</b> Complaints	376
		Office of <b>JUVENILE</b> Affairs	377
		Department of <b>LABOR</b>	380
		Department of the Commissioners of the <b>LAND</b> Office	385
		Council on <b>LAW</b> Enforcement Education and Training	390
		Oklahoma <b>LAW</b> Enforcement Retirement System	395
		Board on <b>LEGISLATIVE</b> Compensation	400

Agency	Title	Agency	Title
Oklahoma Department of <b>LIBRARIES</b> .....	405	Oklahoma <b>SAVINGS</b> and Loan Board ( <i>abolished 7-1-93</i> ) .....	625
<b>LIEUTENANT</b> Governor .....	410	<b>SCENIC</b> Rivers Commission .....	630
Oklahoma <b>LINKED</b> Deposit Review Board .....	415	Oklahoma Commission on <b>SCHOOL</b> and County Funds	
Oklahoma <b>LIQUEFIED</b> Petroleum Gas Board .....	420	Management .....	635
Oklahoma <b>LIQUEFIED</b> Petroleum Gas Research, Marketing and Safety		Advisory Task Force on the Sale of <b>SCHOOL</b> Lands ( <i>functions</i>	
Commission .....	422	<i>concluded 2-92</i> ) .....	640
<b>LITERACY</b> Initiatives Commission .....	425	The Oklahoma School of <b>SCIENCE</b> and Mathematics .....	645
<b>LONG-RANGE</b> Capital Planning Commission .....	428	Oklahoma Center for the Advancement of <b>SCIENCE</b> and	
Oklahoma State Board of Examiners for <b>LONG-TERM</b> Care		Technology .....	650
Administrators ( <i>Formerly:</i> Oklahoma State Board of Examiners		<b>SECRETARY</b> of State .....	655
for <b>NURSING</b> Home Administrators) - <i>See</i> Title 490		Department of <b>SECURITIES</b> .....	660
<b>LOTTERY</b> Commission, Oklahoma .....	429	Board of Regents of <b>SEMINOLE</b> State College ( <i>exempted</i>	
Board of Trustees for the <b>MCCURTAIN</b> County Higher Education		11-1-98) .....	665
Program ( <i>exempted 11-1-98</i> ) .....	430	<b>SHEEP</b> and Wool Commission .....	670
Commission on <b>MARGINALLY</b> Producing Oil and Gas Wells .....	432	State Board of Licensed <b>SOCIAL</b> Workers .....	675
State Board of <b>MEDICAL</b> Licensure and Supervision .....	435	<b>SOUTHERN</b> Growth Policies Board .....	680
<b>MEDICAL</b> Technology and Research Authority of Oklahoma .....	440	Oklahoma <b>SOYBEAN</b> Commission ( <i>abolished 7-1-97</i> ) .....	685
Board of <b>MEDICOLEGAL</b> Investigations .....	445	Board of Examiners for <b>SPEECH-LANGUAGE</b> Pathology and	
Department of <b>MENTAL</b> Health and Substance Abuse Services .....	450	Audiology ( <i>Formerly:</i> Board of Examiners for <b>SPEECH</b>	
<b>MERIT</b> Protection Commission .....	455	Pathology and Audiology) .....	690
<b>MILITARY</b> Planning Commission, Oklahoma Strategic .....	457	<b>STATE</b> Employee Charitable Contributions, Oversight	
Department of <b>MINES</b> .....	460	Committee for ( <i>Formerly:</i> <b>STATE</b> Agency	
Oklahoma <b>MOTOR</b> Vehicle Commission .....	465	Review Committee) .....	695
Board of Regents of <b>MURRAY</b> State College ( <i>exempted 11-1-98</i> ) .....	470	<b>STATE</b> Use Committee ( <i>Formerly:</i> Committee on Purchases of Products	
Oklahoma State Bureau of <b>NARCOTICS</b> and Dangerous Drugs		and Services of the Severely <b>HANDICAPPED</b> ) – <i>See</i> Title 304	
Control .....	475	Oklahoma <b>STUDENT</b> Loan Authority .....	700
Board of Regents of <b>NORTHERN</b> Oklahoma College ( <i>exempted</i>		<b>TASK</b> Force 2000 .....	705
11-1-98) .....	480	Oklahoma <b>TAX</b> Commission .....	710
Oklahoma Board of <b>NURSING</b> .....	485	Oklahoma Commission for <b>TEACHER</b> Preparation .....	712
Oklahoma State Board of Examiners for <b>LONG-TERM</b> Care		<b>TEACHERS'</b> Retirement System .....	715
Administrators ( <i>Formerly:</i> Oklahoma State Board of Examiners		State <b>TEXTBOOK</b> Committee .....	720
for <b>NURSING</b> Home Administrators) .....	490	<b>TOBACCO</b> Settlement Endowment Trust Fund .....	723
Board of Regents of <b>OKLAHOMA</b> City Community College ( <i>exempted</i>		Oklahoma <b>TOURISM</b> and Recreation Department .....	725
11-1-98) .....	495	Department of <b>TRANSPORTATION</b> .....	730
Board of Regents of <b>OKLAHOMA</b> Colleges ( <i>exempted 11-1-98</i> ) .....	500	Oklahoma <b>TRANSPORTATION</b> Authority ( <i>Name changed to</i>	
Board of Examiners in <b>OPTOMETRY</b> .....	505	Oklahoma <b>TURNPIKE</b> Authority 11-1-05) - <i>See</i> Title 731	
State Board of <b>OSTEOPATHIC</b> Examiners .....	510	Oklahoma <b>TURNPIKE</b> Authority ( <i>Formerly:</i> Oklahoma	
<b>PARDON</b> and Parole Board .....	515	<b>TRANSPORTATION</b> Authority AND Oklahoma <b>TURNPIKE</b>	
Oklahoma <b>PEANUT</b> Commission .....	520	Authority) - <i>See</i> also Title 745 .....	731
Oklahoma State <b>PENSION</b> Commission .....	525	State <b>TREASURER</b> .....	735
State Board of Examiners of <b>PERFUSIONISTS</b> .....	527	Board of Regents of <b>TULSA</b> Community College ( <i>exempted</i>	
Board of Commercial <b>PET</b> Breeders .....	532	11-1-98) .....	740
Office of <b>PERSONNEL</b> Management .....	530	Oklahoma <b>TURNPIKE</b> Authority ( <i>Name changed to Oklahoma</i>	
Oklahoma State Board of <b>PHARMACY</b> .....	535	<b>TRANSPORATION</b> Authority 11-1-99 - <i>no rules enacted in this</i>	
<b>PHYSICIAN</b> Manpower Training Commission .....	540	<i>Title - See</i> Title 731) .....	745
Board of <b>PODIATRIC</b> Medical Examiners .....	545	Oklahoma <b>UNIFORM</b> Building Code Commission .....	748
Oklahoma <b>POLICE</b> Pension and Retirement System .....	550	Board of Trustees for the <b>UNIVERSITY</b> Center at Tulsa ( <i>exempted</i>	
State Department of <b>POLLUTION</b> Control ( <i>abolished 1-1-93</i> ) .....	555	11-1-98) .....	750
<b>POLYGRAPH</b> Examiners Board .....	560	<b>UNIVERSITY</b> Hospitals Authority .....	752
Oklahoma Board of <b>PRIVATE</b> Vocational Schools .....	565	<b>UNIVERSITY</b> Hospitals Trust .....	753
State Board for <b>PROPERTY</b> and Casualty Rates		Board of Regents of the <b>UNIVERSITY</b> of Oklahoma ( <i>exempted</i>	
( <i>abolished 7-1-06; see also Title 365</i> ) .....	570	11-1-98) .....	755
State Board of Examiners of <b>PSYCHOLOGISTS</b> .....	575	Board of Regents of the <b>UNIVERSITY</b> of Science and Arts	
Department of <b>CENTRAL</b> Services ( <i>Formerly:</i> Office of <b>PUBLIC</b>		of Oklahoma ( <i>exempted 11-1-98</i> ) .....	760
Affairs) .....	580	Oklahoma <b>USED</b> Motor Vehicle and Parts Commission .....	765
<b>PUBLIC</b> Employees Relations Board .....	585	Oklahoma Department of <b>VETERANS</b> Affairs .....	770
Oklahoma <b>PUBLIC</b> Employees Retirement System .....	590	Board of <b>VETERINARY</b> Medical Examiners .....	775
Department of <b>PUBLIC</b> Safety .....	595	Oklahoma Department of <b>CAREER</b> and Technology Education	
<b>REAL</b> Estate Appraiser Board .....	600	( <i>Formerly:</i> Oklahoma Department of <b>VOCATIONAL</b> and	
Oklahoma <b>REAL</b> Estate Commission .....	605	Technical Education) .....	780
Board of Regents of <b>REDLANDS</b> Community College ( <i>exempted</i>		Oklahoma <b>WATER</b> Resources Board .....	785
11-1-98) .....	607	Board of Regents of <b>WESTERN</b> Oklahoma State College ( <i>exempted</i>	
State <b>REGENTS</b> for Higher Education .....	610	11-1-98) .....	790
State Department of <b>REHABILITATION</b> Services .....	612	Oklahoma <b>WHEAT</b> Commission .....	795
Board of Regents of <b>ROGERS</b> State College ( <i>exempted 11-1-98</i> ) .....	615	Department of <b>WILDLIFE</b> Conservation .....	800
Board of Regents of <b>ROSE</b> State College ( <i>exempted 11-1-98</i> ) .....	620	<b>WILL</b> Rogers and J.M. Davis Memorials Commission .....	805



# Notices of Rulemaking Intent

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

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

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

## **TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 510. CARE OF EYES FOR NEWBORN CHILDREN [REVOKED]**

*[OAR Docket #10-1239]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

Subchapter 1. General Provisions [REVOKED]

310:510-1-1. [REVOKED]

Subchapter 3. Approved Antiseptics [REVOKED]

310:510-3-1. [REVOKED]

Subchapter 5. Recommendations [REVOKED]

310:510-5-1. [REVOKED]

### **SUMMARY:**

310:510 - The current Rule previously identified a one percent (1%) solution of nitrite of silver as medication for care of inflammation of the eyes of the newborn and authorized the State Board of Health to approve the use of antiseptics, other than nitrate of silver, for use, and to prescribe the manner of their use. The statute further mandated reporting of ophthalmia neonatorum and refusal of administration of a prophylactic ophthalmic agent. The revocation of this Chapter is necessary because the Statute amendments in Senate Bill 1817, effective November 1, 2010, remove these reporting requirements and now require any physician, midwife, or other attendant, upon the birth of a newborn infant, to ensure treatment of the eyes of the infant with a prophylactic ophthalmic agent as recommended by the Centers for Disease Control and Prevention as prophylaxis against ophthalmia neonatorum. The statute amendments authorize rulemaking in support of the amendments but no rules are deemed necessary at this time. The statute does not prohibit a parent or legal guardian of a newborn infant from refusing prophylactic treatment on religious grounds or when such person deems that it is in the best interest of the child. If the parent or legal guardian of the newborn infant refuses the prophylactic treatment, the health care provider shall document the refusal in the medical file of the newborn infant.

### **AUTHORITY:**

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-509

### **COMMENT PERIOD:**

November 15, 2010 through December 15, 2010. Interested persons may informally discuss the proposed rules with

Suzanna Dooley, Maternal and Child Health Service; or may, before December 15, 2010, submit written comment to Suzanna Dooley, Maternal and Child Health Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; or may at the hearing, ask to present written or oral views.

### **PUBLIC HEARING:**

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on December 15, 2010, at the Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, in room 1102 from 11:00 a.m. until 1:00 p.m. At the discretion of the presiding official, the meeting may continue beyond 1:00 p.m. if it is necessary to receive all comments from the public. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, about the increase in level of direct costs, indirect costs, or other costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing before December 15, 2010, to Suzanna Dooley, Maternal and Child Health Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, or by e-mail to [suzannad@health.ok.gov](mailto:suzannad@health.ok.gov).

### **COPIES OF PROPOSED RULES:**

The proposed rules may be obtained for review from staff of the Maternal and Child Health Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, via e-mail request to [suzannad@health.ok.gov](mailto:suzannad@health.ok.gov) or via the agency website at [www.health.ok.gov](http://www.health.ok.gov).

### **RULE IMPACT STATEMENT:**

Pursuant to 63 O.S., Section 1-509 et seq., a rule impact statement is available at the location listed above for obtaining copies of the rule.

### **CONTACT PERSON:**

Suzanna Dooley, Chief, Maternal and Child Health Service, phone (405) 271-4480, e-mail [suzannad@health.ok.gov](mailto:suzannad@health.ok.gov).

*[OAR Docket #10-1239; filed 10-26-10]*

### TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 662. HOME CARE AGENCIES

[OAR Docket #10-1238]

#### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

#### **PROPOSED RULES:**

Subchapter 1. General Provisions

310:662-1-2. [AMENDED]

Subchapter 3. Administration

310:662-3-4. [AMENDED]

Subchapter 5. Client Services

310:662-5-3. [AMENDED]

Subchapter 6. Supportive Home Assistant Competency

Testing [NEW]

310:662-6-1. [NEW]

310:662-6-2. [NEW]

310:662-6-3. [NEW]

310:662-6-4. [NEW]

310:662-6-5. [NEW]

#### **SUMMARY:**

The proposed rules are intended to implement the provisions of HB 1736 enacted during the 2009 Regular Session of the Oklahoma Legislature by creating a process for home care agencies to train "supportive home assistants" to provide "standby assistance" and subsequently obtain an independent assessment of the competency of the individuals trained in this skill set. These amendments also create a requirement for licensed home care agencies to establish an influenza control program that includes provisions to vaccinate home care workers against influenza in order to help prevent the transmission of influenza to this vulnerable population through their home health care workers.

310:662-1-2 - This new language amends the current Definitions section of the rule to include the statutory definitions of "Standby assistance" and "Supportive home assistant" so that a reader of the rule does not have to research the Home Care Act in order to find the definition of these terms.

310:662-5-3 - This new language recognizes "supportive home assistant" as a class of caregiver that may be utilized by a licensed home care agency.

Subchapter 6. is a new subchapter of this rule that establishes the process by which an individual who receives training in "standby assistance" through a licensed home care agency must receive an independent evaluation of their competency in this skill set in order to work as a "supportive home assistant." The rules specify the requirements for administration of the competency assessment; the content of the competency examination; defines successful completion of the competency examination; speaks to failure to complete the competency examination, and addresses expiration of the competency assessment.

310:662-3-4 - The proposed rule at this section establishes a new requirement for each licensed home care agency to

implement an influenza control program consistent with Centers for Disease Control and Prevention (CDC) guidelines. This program must include provisions that the agency offer the seasonal influenza vaccination to all employees/workers onsite at no charge to the worker, or obtain a signed declination statement for each worker who refuses the vaccination and other administrative processes necessary to evaluate the effectiveness of the program. This change is necessary because research indicates that vaccination rates for healthcare workers in all settings of care rarely exceed 40%, leaving many of the most vulnerable populations at risk of contracting influenza from their healthcare workers. The proposed rule anticipates the possibility of a shortage of seasonal influenza vaccine and includes a provision to suspend these requirements if a shortage has been recognized by the Commissioner of Health.

#### **AUTHORITY:**

Oklahoma State Board of Health; 63 O.S. Section 1-104 and 63 O.S. Section 1960 et seq.

#### **COMMENT PERIOD:**

November 15, 2010, through December 15, 2010. Interested persons may informally discuss the proposed rules with Tom Welin, Chief, Medical Facilities Service, Protective Health Services; or may, before December 15, 2010, submit written comment to Tom Welin, Chief, Medical Facilities Service, Protective Health Services, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; or may, at the hearing, ask to present written or oral views.

#### **PUBLIC HEARING:**

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on December 15, 2010, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 1102 from 11:00 a.m. until 1:00 p.m. At the discretion of the presiding official, the meeting may continue beyond 1:00 p.m. if it is necessary to receive all comments from the public. Interested persons may attend for the purpose of submitting data, views or arguments, orally or in writing, about the rule proposal described and summarized in this Notice.

#### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, about the increase in level of direct costs, indirect costs, or other costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing before December 15, 2010, to Tom Welin, Chief, Medical Facilities Service, Protective Health Services, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, or by e-mail to tomw@health.ok.gov.

#### **COPIES OF PROPOSED RULES:**

The proposed rules may be obtained for review from staff of the Medical Facilities Service, Protective Health services, Oklahoma State Department of Health, 1000 N.E. 10th Street,

Oklahoma City, OK 73117-1207 or via electronic mail request to medicalfacilities@health.ok.gov.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., §303(D), a rule impact statement is available at the location listed above for obtaining copies of the rule.

**CONTACT PERSON:**

Tom Welin, Chief, Medical Facilities Service, Protective Health Services, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, (405) 271-6576; e-mail to tomw@health.ok.gov.

*[OAR Docket #10-1238; filed 10-26-10]*

**TITLE 325. OKLAHOMA HORSE RACING COMMISSION  
CHAPTER 25. ENTRIES AND DECLARATIONS**

*[OAR Docket #10-1233]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking.

**PROPOSED RULE:**

325:25-1-10. Horses ineligible to start in a race [AMENDED]

**SUMMARY:**

Mr. Constantin A. Rieger, Commission Executive Director, recommends that the rule be amended. Due to the transient nature of the industry in which a horse may run in one state one week and in another state the next week, the entry of a horse frequently occurs without the Certificate of Foal Registration papers being available in the Racing Secretary's Office at entry time. As the rule is currently written, in races that are overfilled, maidens [horses that have never won a race] would have preference over winners, which is not commonplace.

**AUTHORITY:**

75 O.S., §303; Title 3A O.S. §204(A); Oklahoma Horse Racing Commission.

**COMMENT PERIOD:**

Persons wishing to present their views in writing may do so before 4:30 p.m., Monday, December 20, 2010, at the following address: Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107.

**PUBLIC HEARING:**

A public hearing will be held between the hours of 9:00 a.m. and 12:00 p.m. and 1:00 p.m. and 4:30 p.m. on Monday, December 20, 2010, at the following address: Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

The Oklahoma Horse Racing Commission requests that business entities affected by this proposed rule provide the

Commission, within the comment period, in dollar amounts, if possible, the increase in the level of direct costs, indirect costs, or other costs expected to be incurred by the business entity due to compliance with the proposed rule. Business entities may submit this information in writing to the Commission, at the above address, before the close of the comment period on December 20, 2010.

**COPIES OF PROPOSED RULES:**

A copy of the proposed new rule may be obtained from the Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S. §303(D), a rule impact statement will be prepared by November 1, 2010 and may be obtained from the Oklahoma Horse Racing Commission at the above address.

**CONTACT PERSON:**

Bonnie Morris, Agency Rulemaking Liaison, (405) 943-6472.

*[OAR Docket #10-1233; filed 10-25-10]*

**TITLE 600. REAL ESTATE APPRAISER BOARD  
CHAPTER 30. APPRAISAL MANAGEMENT COMPANY REGISTRATION**

*[OAR Docket #10-1229]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

- 600:30-1-1. Purpose [NEW]
- 600:30-1-2. Definitions [NEW]
- 600:30-1-3. Certificate of Registration [NEW]
- 600:30-1-4. Application process [NEW]
- 600:30-1-5. Renewal process [NEW]
- 600:30-1-6. Fee schedule [NEW]
- 600:30-1-7. Change of information [NEW]
- 600:30-1-8. Background investigations [NEW]
- 600:30-1-9. Business entities [NEW]
- 600:30-1-10. Recordkeeping [NEW]
- 600:30-1-11. Severability provision [NEW]

**SUMMARY:**

The proposed new rules are required to replace emergency rules placed into effect to allow for implementation of the Oklahoma Appraisal Management Company Regulation Act. The Act and the emergency rules were effective on January 1, 2011. These rules set forth required administrative guidance on initial and renewal registration of Appraisal Management Companies.

**AUTHORITY:**

Real Estate Appraiser Board, 59 O.S. § 858-829.

**COMMENT PERIOD:**

Persons may submit written or oral comments to Rod Stirman at the offices of the Real Estate Appraiser Board,

## Notices of Rulemaking Intent

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Oklahoma Insurance Department, 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112 during the period November 15, 2010 to December 24, 2010.

### **PUBLIC HEARING:**

A public hearing will be held at 9:30 a.m. on January 7, 2011, in the offices of the Insurance Commissioner of Oklahoma at 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about any increases in the level of direct costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Rod Stirman at the above address during the period during the period November 15, 2010 to December 24, 2010.

### **COPIES OF PROPOSED RULES:**

Copies of proposed rules are available at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department at 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112. Copies of proposed rules may also be obtained by written request to the attention of Rod Stirman, Real Estate Appraiser Board, PO Box 53408, Oklahoma City, OK 73152. A copy of the proposed rules is posted on the Real Estate Appraiser Board website, [www.reab.oid.ok.gov](http://www.reab.oid.ok.gov).

### **RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department at 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112.

### **CONTACT PERSON:**

Rod Stirman, Director, (405) 521-6636.

*[OAR Docket #10-1229; filed 10-19-10]*

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## **TITLE 600. REAL ESTATE APPRAISER BOARD**

### **CHAPTER 35. APPRAISAL MANAGEMENT COMPANY ENFORCEMENT**

*[OAR Docket #10-1228]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

- 600:35-1-1. Purpose [NEW]
- 600:35-1-2. Definitions [NEW]
- 600:35-1-3. Conduct [NEW]
- 600:35-1-4. Complaints [NEW]
- 600:35-1-5. Complaint procedures [NEW]
- 600:35-1-6. Formal complaint [NEW]
- 600:35-1-7. Notice of disciplinary proceedings [NEW]
- 600:35-1-8. Pre-hearing matters [NEW]
- 600:35-1-9. Subpoenas and subpoenas duces tecum [NEW]

- 600:35-1-10. Disciplinary proceedings [NEW]
- 600:35-1-11. Burden of proof, standard of proof [NEW]
- 600:35-1-12. Right to counsel [NEW]
- 600:35-1-13. Rules of evidence [NEW]
- 600:35-1-14. Failure to appear [NEW]
- 600:35-1-15. Oral argument before the Board [NEW]
- 600:35-1-16. Rehearing, reopening or reconsideration of Board decision [NEW]
- 600:35-1-17. Record of hearing [NEW]
- 600:35-1-18. Request for declaratory ruling [NEW]
- 600:35-1-19. Request for rule adoption, amendment or repeal [NEW]
- 600:35-1-20. Severability provision [NEW]

### **SUMMARY:**

The proposed new rules are required to replace emergency rules placed into effect to allow for implementation of the Oklahoma Appraisal Management Company Regulation Act. The Act and the emergency rules were effective on January 1, 2011. These rules set forth required administrative guidance on enforcement of the requirements set forth for Appraisal Management Companies.

### **AUTHORITY:**

Real Estate Appraiser Board, 59 O.S. § 858-829.

### **COMMENT PERIOD:**

Persons may submit written or oral comments to Rod Stirman at the offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112 during the period November 15, 2010 to December 24, 2010.

### **PUBLIC HEARING:**

A public hearing will be held at 9:30 a.m. on January 7, 2011, in the offices of the Insurance Commissioner of Oklahoma at 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about any increases in the level of direct costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Rod Stirman at the above address during the period during the period November 15, 2010 to December 24, 2010.

### **COPIES OF PROPOSED RULES:**

Copies of proposed rules are available at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department at 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112. Copies of proposed rules may also be obtained by written request to the attention of Rod Stirman, Real Estate Appraiser Board, PO Box 53408, Oklahoma City, OK 73152. A copy of the proposed rules is posted on the Real Estate Appraiser Board website, [www.reab.oid.ok.gov](http://www.reab.oid.ok.gov).

### **RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained at the Offices of the Real Estate Appraiser Board, Oklahoma

Insurance Department at 5 Corporate Plaza, 3625 NW 56th St, Ste 100, Oklahoma City, Oklahoma 73112.

**CONTACT PERSON:**

Rod Stirman, Director, (405) 521-6636.

*[OAR Docket #10-1228; filed 10-19-10]*

**TITLE 712. OKLAHOMA COMMISSION FOR TEACHER PREPARATION  
CHAPTER 10. TEACHER PREPARATION PROGRAM ACCREDITATION**

*[OAR Docket #10-1231]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 5. Teacher Preparation Program Accreditation

712:10-5-1 [AMENDED]

712:10-5-2 [AMENDED]

712:10-5-3 [AMENDED]

712:10-5-4 [AMENDED]

Subchapter 7. Teacher Preparation Teacher Assessment

712:10-7-1 [AMENDED]

Appendix A. Competency Examination by Certification Areas [REVOKED]

Appendix A. Competency Examination by Certification Areas [NEW]

**SUMMARY:**

The proposed Teacher Preparation Program Accreditation revisions would align program review and unit accreditation decisions and terminology with those of the National Council for Accreditation of Teacher Education (NCATE) and would eliminate the requirement for an annual public forum by institutions offering a teacher education program. Revisions also include the requirement that teacher candidate coursework include the study of substance abuse and mental illness symptoms identification and prevention; classroom management skills; and classroom safety and discipline issues. The proposed Assessment rule changes would clarify testing requirements for individuals wishing to add a teaching certification area to an existing license or standard certificate in Speech Language Pathologist, School Nurse, School Psychometrist and/or School Psychologist.

**AUTHORITY:**

Oklahoma Commission for Teacher Preparation; 70 O.S. Supp. 1998, §6-180 et seq.; Oklahoma Teacher Preparation Act

**COMMENT PERIOD:**

Persons wishing to present their views orally or in writing may do so before 4:30 p.m. by December 15, 2010 at the following address: Ted Gillispie, Oklahoma Commission For Teacher Preparation, 3545 NW 58<sup>th</sup> Street, Suite 200, Oklahoma City, OK 73112-4725.

**PUBLIC HEARING:**

A public hearing will be held from 9:00 a.m. to 11:00 a.m. on Wednesday, December 15, 2010 in the Gene Howard Board Room, Landmark Towers, 3545 NW 58<sup>th</sup> St., Oklahoma City, OK, 73112-4725.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the agency within the comment period, with information, in dollar amounts if possible, about he increase in the level of direct costs, indirect costs, or other costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Ted Gillispie, at the above address, before the close of the comment period.

**COPIES OF PROPOSED RULES:**

Copies of the proposed rule may be obtained from the Commission for Teacher Preparation, 3545 NW 58<sup>th</sup> Street, Suite 200, Oklahoma City, OK 73112-4725.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., §303 (D), a rule impact statement will be prepared and may be obtained from the Commission for Teacher Preparation at the above address beginning on November 30, 2010.

**CONTACT PERSON:**

Ted Gillispie, Executive Director, (405) 525-2612

*[OAR Docket #10-1231; filed 10-20-10]*

**TITLE 785. OKLAHOMA WATER RESOURCES BOARD  
CHAPTER 35. WELL DRILLER AND PUMP INSTALLER LICENSING**

*[OAR Docket #10-1234]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 1. General Provisions

785:35-1-4. Violations and penalties [AMENDED]

Subchapter 5. General Requirements to Maintain Licenses and Operator Certifications

785:35-5-3. Requirements for multi-purpose completion report [AMENDED]

Subchapter 7. Minimum Standards for Construction of Wells

785:35-7-1. Minimum standards for construction of groundwater wells, fresh water observation wells, and water well test holes [AMENDED]

785:35-7-2. Minimum standards for construction of monitoring wells and geotechnical borings [AMENDED]

785:35-7-3. Variances to minimum standards for construction of wells [AMENDED]

## Notices of Rulemaking Intent

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### SUMMARY:

Staff proposes to recommend that the Board amend rules to establish an administrative fine schedule for violation of specific rules and to provide for issuance of administrative citations which will advise the person violating specified rules of a hearing date at which the person may contest the issuance of the citation and/or amount of the fine; to require that all monitoring well and geotechnical boring multi-purpose completion reports be submitted electronically online unless a waiver of such requirement is granted and specifying process to request waiver; to revise the a separation distance from a water well to an aerobic spray area for a septic system from fifteen feet (15') to twenty-five feet (25'); to allow the use of bentonite chips as well as bentonite pellets for the filter pack seal for monitoring well construction; and to remove the notary requirement for variance request. The circumstance creating the need for the proposed amendments include the comments and suggestions from the Well Drillers and Pump Installers Advisory Council and issues arising in the implementation of the program by staff during the preceding year.

Other amendments may be considered and adopted as a result of public comments.

### AUTHORITY:

Oklahoma Water Resources Board general authority and duties in 82 O.S. Section 1085.2; Oklahoma Groundwater Law in 82 O.S. Section 1020.1 and following, particularly Section 1020.16 on well driller and pump installer licensing.

### COMMENT PERIOD:

Persons may submit written comments to Julie Cunningham, Chief, Planning and Management Division, by mailing written comments to 3800 North Classen Boulevard, Oklahoma City, Oklahoma 73118, during the period from November 15, 2010, to January 11, 2011. In addition, persons may submit oral or written comments during the public hearing described below.

### PUBLIC HEARING:

A public hearing will be held during the regular meeting of the Board that is scheduled to begin at 9:30 a.m. on January 11, 2011, at the offices of the Oklahoma Water Resources Board, 3800 North Classen Boulevard in Oklahoma City, Oklahoma.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The OWRB requests that any business entities affected by these proposed rules provide to the OWRB, within the Comment Period from November 15, 2010 through January 11, 2011, in dollar amounts if possible, the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rules. Business entities may submit this information in writing to Kent Wilkins at 3800 North Classen, Oklahoma City, Oklahoma 73118 before 5:00 P.M. on January 11, 2011.

### COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the Oklahoma Water Resources Board, 3800 North Classen

Boulevard, Oklahoma City, Oklahoma 73118, upon prepayment of the copying charge, or on the Board's web site, [www.owrb.ok.gov](http://www.owrb.ok.gov).

### RULE IMPACT STATEMENT:

Pursuant to 75 O.S., § 303(D), a Rule Impact Statement will be available for review at the OWRB's office, 3800 North Classen, Oklahoma City, Oklahoma. The Rule Impact Statement may also be viewed on the OWRB web site at [www.owrb.ok.gov](http://www.owrb.ok.gov).

### CONTACT PERSON:

Kent Wilkins, Well Driller Licensing Administrator, 405-530-8800.

*[OAR Docket #10-1234; filed 10-26-10]*

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## TITLE 785. OKLAHOMA WATER RESOURCES BOARD CHAPTER 45. OKLAHOMA'S WATER QUALITY STANDARDS

*[OAR Docket #10-1235]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 5. Surface Water Quality Standards

Part 3. Beneficial Uses and Criteria to Protect Uses

785:45-5-12. Fish and wildlife propagation [AMENDED]

785:45-5-13. Agriculture [AMENDED]

785:45-5-16. Primary Body Contact Recreation  
[AMENDED]

Appendix A.1. Designated Beneficial Uses of Surface  
Waters Water Quality Management Basin 1, Middle  
Arkansas River [REVOKED]

Appendix A.1. Designated Beneficial Uses of Surface  
Waters Water Quality Management Basin 1, Middle  
Arkansas River [NEW]

### SUMMARY:

The Oklahoma Water Resources Board ("OWRB") is proposing to amend, or is considering amending, various provisions of Oklahoma Administrative Code ("OAC") 785:45 as follows:

Several amendments are being proposed to be responsive to comments made by the U.S. Environmental Protection Agency ("EPA") regarding the State of Oklahoma's draft 2010 list of waterbodies with beneficial uses that are not supported with respect to specified pollutants (referred to as the "303(d) list"). The amendments being proposed include adding or modifying assessment procedures for listing and reporting beneficial use support with respect to Fish and Wildlife Propagation (regarding dissolved oxygen in OAC 785:45-5-12), Agriculture (in 785:45-5-13), and Primary Body Contact Recreation (regarding E. coli, enterococci and fecal coliform, in 785:45-5-16). The circumstance which created the need for these amendments is that EPA has made an

interpretation under the federal Clean Water Act and Code of Federal Regulations to the effect that the pertinent use support assessment procedures currently codified in OAC 785:46 Subchapter 15 are inadequately covered in OAC 785:45 as water quality standards. The intended effects of the proposed amendments are to satisfy EPA's comments on the draft 303(d) list for 2010, to insure that the pertinent assessment procedures are treated as water quality standards, and to avoid action by EPA to take over some or all of development of the 303(d) list for Oklahoma.

OAC 785:45-5-16, Primary Body Contact Recreation, is also proposed to be amended in two other ways. The first of these additional amendments is to delete the criteria for fecal coliform. This amendment is needed because EPA guidance has recommended that in order to protect the Primary Body Contact Recreation use; fecal coliform criteria should be replaced with E. coli and enterococci criteria. The latter criteria have already been promulgated in Oklahoma. The intended effect of this amendment is to remove criteria that have been demonstrated to be poor indicators for protecting body contact recreation.

The second additional amendment of OAC 785:45-5-16 is to clarify that single sample maximum criteria are to be used for swimming advisories only. This amendment is needed because EPA guidance has recommended that single sample maximum criteria are not appropriate for determining beneficial use support. The intended effect of this amendment is to remove criteria that have been demonstrated to be poor indicators for protecting body contact recreation.

Appendix A.1, Designated Beneficial Uses of Surface Waters Water Quality Management Basin 1, Middle Arkansas River, is proposed to be revoked and reenacted with the addition of an HQW designation for Saline Creek and Little Saline Creek, tributaries to Lake Hudson. The circumstance which created the need for this amendment is that affected landowners in the area have requested this designation. The basis for the request include evidence that historic water quality and physical habitat provide conditions which are better than the promulgated criteria in OAC 785:45 Appendix G, and there is significant local support for promulgation of the HQW designation. The intended effect of this revision is to provide consistent protection for all waters with similar environmental conditions.

Other amendments may be considered as a result of public comments.

**AUTHORITY:**

Oklahoma Water Resources Board, 82 O.S., §§ 1085.30 and 1085.30a; 27A O.S., § 1-3-101; and 82 O.S., § 1085.2.

**COMMENT PERIOD:**

Persons wishing to present data, views, or arguments orally or in writing may do so at 3800 North Classen, Oklahoma City, Oklahoma 73118 before 5:00 P.M. on January 10, 2011.

**PUBLIC HEARING:**

A public hearing will be held January 11, 2011 at 9:30 A.M. in the Board Room of the OWRB's offices located at 3800 North Classen, Oklahoma City, Oklahoma.

**REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

The OWRB requests that any business entities affected by these proposed rules provide the OWRB, within the Comment Period from November 15, 2010 through January 10, 2011, in dollar amounts if possible, the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rules. Business entities may submit this information in writing to Phillip Moershel at 3800 North Classen, Oklahoma City, Oklahoma 73118 before 5:00 P.M. on January 10, 2011.

**COPIES OF PROPOSED RULES:**

Copies of the proposed amendments may be reviewed at the OWRB's office location at 3800 North Classen, Oklahoma City, Oklahoma 73118, or may be obtained from the "Contact Person" identified below upon prepayment of the copying charge. The proposed amendments may also be viewed on the OWRB web site at <http://www.owrb.ok.gov>.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., § 303(D), a Rule Impact Statement is available for review at the OWRB's office, 3800 North Classen, Oklahoma City, Oklahoma. The Rule Impact Statement may also be viewed on the OWRB web site at <http://www.owrb.ok.gov>.

**CONTACT PERSON:**

Phillip Moershel, Water Quality Standards Section Head, 405/530-8800.

*[OAR Docket #10-1235; filed 10-26-10]*

**TITLE 785. OKLAHOMA WATER RESOURCES BOARD  
CHAPTER 46. IMPLEMENTATION OF OKLAHOMA'S WATER QUALITY STANDARDS**

*[OAR Docket #10-1236]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Chapter 46. Implementation of Oklahoma's Water Quality Standards [AMENDED]

**SUMMARY:**

The Oklahoma Water Resources Board ("OWRB") is proposing to amend, or is considering amending, various provisions of Oklahoma Administrative Code ("OAC") 785:46 as follows:

OAC 785:46-15-4, Default protocols, is proposed to be amended in (c)(2) to correct a logical error by replacing a reference to "average" and changing the wording to the term "criterion". The intended effect of this amendment is to clarify that data should be compared to the criterion.

## Notices of Rulemaking Intent

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Several amendments to OAC 785:46 Subchapter 15 are being proposed to be responsive to comments made by the U.S. Environmental Protection Agency ("EPA") regarding the State of Oklahoma's draft 2010 list of waterbodies with beneficial uses that are not supported with respect to specified pollutants (referred to as the "303(d) list"), and to address technical issues encountered by state environmental agencies in preparing the draft 2010 list. The amendments being proposed include adding or modifying assessment procedures for listing and reporting beneficial use support with respect to Fish and Wildlife Propagation (regarding dissolved oxygen and temperature), Agriculture (total dissolved solids, chloride and sulfate), Primary Body Contact Recreation (regarding E. coli, enterococci and fecal coliform), Public and Private Water Supply (total coliform) and Navigation. The circumstances which created the need for these amendments are that in preparing the 2010 list state environmental agencies encountered inconsistencies in the rules, and that EPA has made an interpretation under the federal Clean Water Act and Code of Federal Regulations to the effect that the pertinent use support assessment procedures currently codified in OAC 785:46 Subchapter 15 are inadequately covered in OAC 785:45 as water quality standards. The intended effects of the proposed amendments are to satisfy EPA's comments on the draft 303(d) list for 2010, to insure that the pertinent assessment procedures are consistent with water quality standards and technically sound, and to avoid action by EPA to take over some or all of development of the 303(d) list for Oklahoma.

OAC 785:46-19-3, Reasonable potential determination for dissolved oxygen, is proposed to be revised to add increased flow or load as triggers for reasonable potential. This amendment has been requested by the Oklahoma Department of Environmental Quality. The intended effect is to eliminate an ambiguity in the current rule that could allow water quality impairment.

Other amendments may be considered as a result of public comments.

### **AUTHORITY:**

Oklahoma Water Resources Board, 82 O.S., § 1085.30; 27A O.S., § 1-3-101; and 82 O.S., § 1085.2.

### **COMMENT PERIOD:**

Persons wishing to present data, views, or arguments orally or in writing may do so at 3800 North Classen, Oklahoma City, Oklahoma 73118 before 5:00 P.M. on January 10, 2011.

### **PUBLIC HEARING:**

A public hearing will be held January 11, 2011 at 9:30 A.M. in the Board Room of the OWRB's offices located at 3800 North Classen, Oklahoma City, Oklahoma.

### **REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

The OWRB requests that any business entities affected by these proposed rules provide the OWRB, within the Comment Period from November 15, 2010 through January 10, 2011, in dollar amounts if possible, the increase in the level of

direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rules. Business entities may submit this information in writing to Phillip Moershel at 3800 North Classen, Oklahoma City, Oklahoma 73118 before 5:00 P.M. on January 10, 2011.

### **COPIES OF PROPOSED RULES:**

Copies of the proposed amendments may be reviewed at the OWRB's office location at 3800 North Classen, Oklahoma City, Oklahoma 73118, or may be obtained from the "Contact Person" identified below upon prepayment of the copying charge. The proposed amendments may also be viewed on the OWRB web site at <http://www.owrb.ok.gov>.

### **RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., § 303(D), a Rule Impact Statement is available for review at the OWRB's office, 3800 North Classen, Oklahoma City, Oklahoma. The Rule Impact Statement may also be viewed on the OWRB web site at <http://www.owrb.ok.gov>.

### **CONTACT PERSON:**

Phillip Moershel, Water Quality Standards Section Head, 405/530-8800.

*[OAR Docket #10-1236; filed 10-26-10]*

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## **TITLE 785. OKLAHOMA WATER RESOURCES BOARD CHAPTER 50. FINANCIAL ASSISTANCE**

*[OAR Docket #10-1237]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

Subchapter 3. Projects and Entities Eligible

785:50-3-1. Project eligibility [AMENDED]

785:50-3-2. Eligible entities [AMENDED]

Subchapter 9. Clean Water State Revolving Fund Regulations

Part 1. General Provisions

785:50-9-9. Definitions [AMENDED]

Part 3. General Program Requirements [AMENDED]

785:50-9-21. Eligible project [AMENDED]

785:50-9-23. Clean Water SRF Project Priority System [AMENDED]

785:50-9-24. Intended use plan [AMENDED]

785:50-9-30. Planning documents [AMENDED]

785:50-9-45. Compliance with federal authorities [AMENDED]

Part 7. SRF Environmental Review Process

785:50-9-62. Environmental review by the Board [AMENDED]

**SUMMARY:**

The Oklahoma Water Resources Board ("OWRB") proposes to amend this Chapter of the Oklahoma Administrative Code ("OAC") as follows:

Sections 785:50-3-1, 785:50-9-9, 785:50-9-21, 785:50-9-23, and 785:50-9-24 are proposed to be amended to change language regarding "urban storm water activities" to "storm water" and "Brownfield activities". These changes are proposed to modify language so that it corresponds with the other sections of Chapter 50. The intended use is to make this language consistent throughout Chapter 50.

Section 785:50-3-2 is proposed to be amended to change "REP" to "REAP". This change is proposed to correct a typographical error. The intended effect is to provide the correct acronym for the Rural Economic Action Plan.

Sections 785:50-9-9 is proposed to be amended to include a definition of "consultant". This change is proposed to clarify who may act and be paid as a consultant under the State Revolving Fund ("SRF") Loan programs. The intended effect is to ensure service providers are meeting the requirements of Oklahoma law.

Sections 785:50-9-21 and 785:50-9-30 are proposed to be amended to provide for greater flexibility in engineering requirements of loans for the Clean Water SRF projects. These amendments will correspond to the changes created by the Environmental Protection Agency ("EPA"). The intended effect of the proposed amendments is to make the rules consistent with the engineering process and other loan terms allowed by state and federal law.

Section 785:50-9-23 is proposed to be amended to include programmatic priorities set forth by the EPA or the OWRB. The intended effect of the proposed amendment is to allow flexibility in the scoring criteria to reflect the current priorities of the EPA or the OWRB.

It is additionally proposed to amend Section 785:50-9-23 to change "non-point" source to "nonpoint" source. This change is proposed to correct a typographical error. The intended effect is to make this language consistent throughout Chapter 50.

Section 785:50-9-30 is proposed to be amended to include planning documents that do not require the findings of an engineer. These changes are proposed to incorporate projects that have a design plan that is not completed by an engineer but are still considered eligible projects under EPA guidelines. The intended effect of the proposed amendment is to increase the flexibility of the planning document criteria.

A final proposal to amend Section 785:50-9-30 is to include the term "registered financial advisor" in place of "financial advisor". This change is proposed to clarify who may act and be paid as a financial advisor under the SRF programs. The intended effect is to ensure all financial advisors are meeting the requirements of Oklahoma law.

Section 785:50-9-45 is proposed to be amended to include those laws that are required to be included in loan agreements and other funding documents under the Clean Water SRF

Program. The intended effect of the proposed amendment is to remain current with EPA regulations.

Section 785:50-9-62 is proposed to be amended to provide for greater flexibility in environmental requirements of loans for the Clean Water SRF projects. These amendments will correspond to the changes created by the EPA. The intended effect of the proposed amendments is to make the rules consistent with the environmental process and other loan terms allowed by state and federal law.

Other amendments may be considered as a result of public comments.

**AUTHORITY:**

Oklahoma Water Resources Board; 82 O.S. § 1085.2; 82 O.S. §§ 1085.31 et seq.; 82 O.S. §§ 1085.51 et seq.; 62 O.S. § 2003.

**COMMENT PERIOD:**

Persons wishing to present data, views, or arguments orally or in writing may do so at 3800 North Classen, Oklahoma City, Oklahoma 73118 before 5:00 P.M. on January 10, 2011.

**PUBLIC HEARING:**

A public hearing is scheduled for January 11, 2011, beginning at 9:30 A.M. in the Board Room of the OWRB's offices located at 3800 North Classen, Oklahoma City, Oklahoma.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

The OWRB requests that any business entities affected by these proposed rules provide to the OWRB, within the Comment Period from November 15, 2010 through January 10, 2011, in dollar amounts if possible, the increase in the level of direct costs such as fees, and indirect costs such as reporting, record keeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rules. Business entities may submit this information in writing to Kate Burum at 3800 North Classen, Oklahoma City, Oklahoma 73118 before 5:00 P.M. on January 10, 2011.

**COPIES OF PROPOSED RULES:**

Copies of the proposed rules may be obtained from the Oklahoma Water Resources Board, 3800 North Classen Boulevard, Oklahoma City, Oklahoma 73118, upon prepayment of the copying charge, or on the OWRB's web site, [www.owrb.ok.gov](http://www.owrb.ok.gov).

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., § 303(D), a Rule Impact Statement is available for review at the OWRB's office, 3800 North Classen, Oklahoma City, Oklahoma. The Rule Impact Statement may also be viewed on the OWRB web site at [www.owrb.ok.gov](http://www.owrb.ok.gov).

**CONTACT PERSON:**

Kate Burum, Staff Attorney and Funds Manager, 405-530-8800.

*[OAR Docket #10-1237; filed 10-26-10]*



# Emergency Adoptions

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

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

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

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

## TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 15. ANIMAL INDUSTRY

[OAR Docket #10-1223]

### RULEMAKING ACTION:

EMERGENCY adoption

### RULES:

Subchapter 22. Swine Pseudorabies  
Part 3. Requirements for Swine Entering Oklahoma  
35:15-22-33 [AMENDED]

### AUTHORITY:

Oklahoma Constitution, Article 6, § 31; and the Oklahoma Agricultural Code, 2 O.S. §§ 2-4(2), (7), and (29), and 6-2 (Supp.2009)

### DATES:

#### Adoption:

August 18, 2010

#### Approved by Governor:

September 17, 2010

#### Effective:

Immediately upon Governor's approval

#### Expiration:

Effective through July 14, 2011 unless superseded by another rule or disapproved by the Legislature

#### SUPERSEDED EMERGENCY ACTIONS:

N/A

#### INCORPORATIONS BY REFERENCE:

N/A

#### FINDING OF EMERGENCY:

This emergency rule is necessary to protect the swine industry and to protect youth swine exhibition in Oklahoma and ensure parents and agriculture teachers are not deemed violators. As a result, a compelling public interest exists requiring the passage of this rule.

#### ANALYSIS:

The emergency rule allows persons who import exhibition swine into Oklahoma to do so on weekends and after hours when it is not possible to obtain all appropriate testing prior to entry. In recent months, both parents and agriculture teachers intending to purchase swine for youth exhibition have been burdened with trying to obtain the appropriate import documents when they are only able to buy on the weekend. Typically, it is impossible for these buyers to obtain the necessary testing and documents because their purchases are often on the weekends or after normal business hours. Without this emergency rule, the person bringing the exhibition swine to Oklahoma would be violating the statutes and rules associated with importation of swine. A certificate of veterinary inspection continues to be required for all imports and the exhibition swine will remain under quarantine until appropriate testing is negative.

#### CONTACT PERSON:

Dr. Becky Brewer-Walker, (405) 522-6142

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE**

**UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):**

## SUBCHAPTER 22. SWINE PSEUDORABIES

### PART 3. REQUIREMENTS FOR SWINE ENTERING OKLAHOMA

#### 35:15-22-33. Entry requirements for transitional production exhibition and prospective exhibition swine

(a) A person importing transitional production exhibition or prospective exhibition swine into Oklahoma shall obtain an entry permit from the Department.

(b) Transitional production exhibition and prospective exhibition swine entering Oklahoma shall be accompanied by a certificate of veterinary inspection issued a maximum of thirty (30) calendar days prior to entry, containing the following information:

- (1) the entry permit number,
- (2) a statement from the issuing veterinarian that to the best of the veterinarian's knowledge pseudorabies ~~has~~ and brucellosis have not existed in the herd of origin in the past six (6) months, the swine to be imported have not been vaccinated for pseudorabies, and if applicable, the swine to be imported are offspring of a pseudorabies vaccinated sow, ~~and~~
- (3) date of negative test for pseudorabies and brucellosis, and
- (~~3~~4) if applicable, the validated/qualified herd number and ~~date~~ dates of last pseudorabies ~~test~~ and brucellosis tests.

(c) Transitional production exhibition and prospective exhibition swine that are offspring of a pseudorabies and brucellosis vaccinated sow shall be accompanied with an individual negative pseudorabies and brucellosis test using ~~an~~ official pseudorabies ~~test~~ and brucellosis tests recognized by Oklahoma.

(d) Transitional production exhibition and prospective exhibition swine entering Oklahoma shall either:

- (1) be accompanied with a negative official pseudorabies and brucellosis test performed within thirty (30) calendar days prior to entry, or

## Emergency Adoptions

(2) originate from a qualified pseudorabies ~~negative~~ and brucellosis validated herd.

(e) An exception to import test requirements may be issued by the Department to purchasers of exhibition swine. To qualify for the exception, prospective purchasers of exhibition swine shall:

(1) Apply for an anticipatory entry permit during the Department's office hours prior to traveling to a state where swine for exhibition purposes are proposed to be purchased;

(2) Contact the Department on the next business day following a purchase to report the number of swine purchased and the seller of the swine or to notify the Department no swine were purchased on the anticipatory entry permit;

(3) Obtain a certificate of veterinary inspection issued a maximum of thirty (30) calendar days prior to entry for the movement of the swine; and

(4) Immediately quarantine any swine entering Oklahoma for exhibition purposes pursuant to this subsection until tested negative for brucellosis and pseudorabies within thirty (30) calendar days of entry.

[OAR Docket #10-1223; filed 10-15-10]

### TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 37. FOOD SAFETY

[OAR Docket #10-1222]

#### **RULEMAKING ACTION:**

EMERGENCY adoption

#### **RULES:**

Subchapter 13. Milk and Milk Products  
35:37-13-7 [NEW]

#### **AUTHORITY:**

Oklahoma Constitution, Article 6, § 31; and the Oklahoma Agricultural Code, 2 O.S. §§ 2-4(2), (7), and (29), and 7-408(E) (Supp.2009)

#### **DATES:**

##### **Adoption:**

August 18, 2010

##### **Approved by Governor:**

September 17, 2010

##### **Effective:**

Immediately upon Governor's approval

##### **Expiration:**

Effective through July 14, 2011 unless superseded by another rule or disapproved by the Legislature

##### **SUPERSEDED EMERGENCY ACTIONS:**

N/A

##### **INCORPORATIONS BY REFERENCE:**

N/A

##### **FINDING OF EMERGENCY:**

The 2010 Legislature through the passage of House Bill 3398 mandated the Department to charge inspection fees for milk related permits. As a result, a compelling public interest exists requiring the passage of this rule.

##### **ANALYSIS:**

The emergency rule allows the Department to charge a fee to conduct milk tanker inspections.

##### **CONTACT PERSON:**

Teena Gunter, (405) 522-4576

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

### SUBCHAPTER 13. MILK AND MILK PRODUCTS

#### **35:37-13-7. Inspection fees**

(a) The Department shall conduct inspections of milk tankers associated with milk transportation company permits pursuant to 2 O.S. § 7-408(B).

(b) The Department shall charge a fee of \$75.00 per milk tanker inspected.

[OAR Docket #10-1222; filed 10-15-10]

### TITLE 230. STATE ELECTION BOARD CHAPTER 30. ABSENTEE VOTING

[OAR Docket #10-1230]

#### **RULEMAKING ACTION:**

EMERGENCY adoption

#### **RULES:**

Subchapter 13. Federal Write-in Absentee Ballot

230:30-13-1. Voters permitted to use federal write-in absentee ballots [AMENDED]

230:30-13-3. Rules for counting federal write-in absentee ballots [AMENDED]

Subchapter 15. State Write-in Absentee Ballot

230:30-15-1. Voters eligible to use state write-in absentee ballot [AMENDED]

230:30-15-3. Time for state write-in absentee ballot applications [AMENDED]

230:30-15-4. State write-in absentee ballot provided by State Election Board [AMENDED]

230:30-15-5. Processing applications for state write-in absentee ballots [AMENDED]

230:30-15-6. List of candidates [AMENDED]

230:30-15-7. Voters who request both regular and state write-in absentee ballots [AMENDED]

230:30-15-9. Rules for counting state write-in absentee ballots [AMENDED]

#### **AUTHORITY:**

Title 26 O.S., Section 2-107. Secretary of the State Election Board

#### **DATES:**

##### **Adoption:**

August 30, 2010

##### **Approved by Governor:**

October 12, 2010

##### **Effective:**

Immediately upon Governor's approval

##### **Expiration:**

Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature.

##### **SUPERSEDED EMERGENCY ACTIONS:**

n/a

##### **INCORPORATION BY REFERENCE:**

n/a

##### **FINDING OF EMERGENCY:**

The Secretary of the State Election Board finds that the following compelling public interests exist requiring the adoption of emergency rules.

Senate Bill 2142 became effective July 1, 2010. It amends Title 26, Section 14-120.1, which authorizes the use of a special state write-in absentee ballot

by uniformed services and overseas absentee voters. The amendments expand the special state write-in absentee ballot to include statewide offices. This new provision will affect the write-in ballots issued for the November 2, 2010, General Election.

These emergency amendments apply the amended law to the procedures for issuing and for counting special state write-in absentee ballots. Emergency amendments also authorize uniformed services and overseas absentee voters to use the federal write-in absentee ballot to vote for statewide offices in Oklahoma and for the County Election Board to count such votes.

The Secretary finds that these emergency rules are necessary to conform the administrative rules to the amended law, as well as to include appropriate procedures to implement the new law, and that these needs meet the compelling public interest standard for the adoption of emergency rules.

**ANALYSIS:**

Members of the military and the other uniformed services and citizens who live or work overseas, whether on a temporary or long-term basis, as well as the eligible spouses and dependents of these persons, have a more difficult experience with absentee voting than other voters who receive their absentee ballots by mail. There often is not enough time for these voters to receive their ballots by mail and to return them by mail in time for them to be counted. Several services are available to these voters that are intended to ensure their ability to vote for federal offices, among them special write-in absentee ballots.

There are two types of write-in absentee ballots - the federal write-in absentee ballot which is available from the Federal Voting Assistance Program within the U.S. Department of Defense, and the state write-in absentee ballot available from County Election Boards in Oklahoma.

In the past, write-in absentee ballots have been counted only for federal offices. Senate Bill 2142, which became effective on July 1, 2010, expanded the state write-in absentee ballot to include statewide offices. In order to maintain consistency and reduce confusion both for voters who use these special ballots and for the County Election Board personnel who process them, we also are expanding the use of the federal write-in absentee ballot to include statewide offices.

**CONTACT PERSON:**

Suzanne Cox, Publications Editor, State Election Board. Telephone: (405) 521-2391. [scox@elections.ok.gov](mailto:scox@elections.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(D):**

**SUBCHAPTER 13. FEDERAL WRITE-IN ABSENTEE BALLOT**

**230:30-13-1. Voters permitted to use federal write-in absentee ballots**

Absent uniformed services voters, those who are on active duty and absent from their voting residence, and overseas voters, those who are living outside the territorial limits of the United States, shall be permitted to use the federal write-in absentee ballot in Primary, Runoff Primary, Presidential Preferential Primary, and General Elections for statewide and federal offices. These absent uniformed services voters and overseas voters may use the federal write-in absentee ballot whether or not they have applied for regular absentee ballots.

**230:30-13-3. Rules for counting federal write-in absentee ballots**

Federal write-in absentee ballots shall be counted as outlined in 230:30-19-6. The following rules also shall apply:

(1) Before a federal write-in absentee ballot is counted, the Secretary of the County Election Board shall verify that regular absentee ballots have not been received from the voter. See 230:30-13-2(5)-230:30-13-2(4).

(2) A federal write-in absentee ballot may be counted only for statewide and federal offices in Primary, Runoff Primary, Presidential Preferential Primary, and General Elections. The following are the statewide offices that may appear on the state write-in absentee ballot: Governor; Lieutenant Governor; State Auditor and Inspector; Attorney General; State Treasurer; State Superintendent of Public Instruction; Commissioner of Labor; Insurance Commissioner; Corporation Commissioner. The following are the federal offices that may appear on the state write-in absentee ballot: President, Vice President, United States Senator and United States Representatives.

(3) ~~The~~ On a federal write-in absentee ballot submitted for the Primary, Runoff Primary, or Presidential Preferential Primary Election, the voter may designate a candidate by writing the name of a candidate or by writing the name of a political party. On a federal write-in absentee ballot submitted for the General Election, the voter may write either the name of a candidate or the name of a political party. If the voter has written the name of a political party the ballot shall be counted for all the candidate-candidates of that party in ~~a~~ the General Election.

(4) In the case of the offices of President and Vice President, a vote for a named candidate or a vote by writing the name of a political party shall be counted as a vote for the electors supporting the candidate involved.

(5) Any abbreviation, misspelling or other minor variation in the form of the name of a candidate or a political party shall be disregarded in determining the validity of the ballot, so long as the intention of the voter can be ascertained.

(6) In the event that the voter's intent cannot be determined, the federal write-in absentee ballot shall not be counted.

**SUBCHAPTER 15. STATE WRITE-IN ABSENTEE BALLOT**

**230:30-15-1. Voters eligible to use state write-in absentee ballot**

Uniformed services voters and overseas voters who cannot vote by regular mail absentee ballot because of the time required for ballot transit may request the state write-in absentee ballot. The state write-in absentee ballot may be used to vote only for statewide and federal candidates in the Primary, Runoff Primary and General Elections. It also may be used in the Presidential Preferential Primary Election.

**230:30-15-3. Time for state write-in absentee ballot applications**

Uniformed services voters and overseas voters eligible to use the state write-in absentee ballot may apply for it within 90

# Emergency Adoptions

days before an election that involves candidates for statewide or federal candidates offices.

## 230:30-15-4. State write-in absentee ballot provided by State Election Board

(a) The State Election Board will provide the Secretary of the County Election Board with a ~~PDF file template~~ of each state write-in absentee ballot not less than 90 days before an election involving federal candidates for statewide offices and/or candidates for federal offices.

(b) Upon receipt of the state write-in absentee ~~ballots templates~~ from the State Election Board, the following procedure shall be observed:

- (1) Save the ~~PDF~~ file or files on the County Election Board computer.
- (2) Write or stamp "Special Write-In Ballot" on several red-and-white outer envelopes.
- (3) Place the prepared outer envelopes in a secure place until an application for the state write-in absentee ballot is received.

## 230:30-15-5. Processing applications for state write-in absentee ballots

(a) When an application for a state write-in absentee ballot is received from a uniformed services voter or an overseas voter, the following procedure shall be observed to prepare and transmit the ballot by regular mail:

(1) If the application is for a Primary or Runoff Primary Election, determine the voter's political affiliation. See item 7 on the FPCA. If the voter does not indicate a political affiliation in the application for a Primary ~~or~~ Runoff Primary, or Presidential Preferential Primary Election, contact the State Election Board for additional instructions the voter will not receive the state write-in absentee ballot for the Primary, Runoff Primary, or Presidential Preferential Primary Election.

(2) ~~Determine~~ Select and prepare the appropriate state write-in absentee ballot for the voter.

- (A) Open the appropriate ballot template.
- (B) Enter the correct ballot number in the space provided on the ballot stub.
- (C) Enter the county name in the spaces provided on the stub and on the ballot.
- (D) Enter the correct United States Representative District number in the space provided on the ballot.

(3) Print one copy of the appropriate state write-in absentee ballot.

(4) ~~Number the stub of the state write in absentee ballot by hand. Record the number on the appropriate State Write in Absentee Ballot Accounting Form.~~

(5) ~~Enter the appropriate Congressional district number in the blank space on the ballot.~~

(6) Cut the ballot from the stub.  
(5) ~~Assemble~~ Prepare and print the following ~~materials and mail them to the voter documents:~~

- (A) ~~the appropriate ballot.~~
- (B) ~~a copy of the letter to the voter~~ Dear Voter letter.

(C) ~~B) a copy of Instructions for Voting by Write-In Absentee Ballot.~~

(D) ~~C) a uniformed services/overseas absentee voter packet. Use the outer envelopes with "Special Write in Ballot" written or stamped on the front.~~

(E) ~~a list of candidates for the offices~~ Candidate List, if available. See 230:30-15-6.

(6) ~~Prepare a red-and-white uniformed services/overseas voter packet for the voter, using the outer envelopes labeled "Special Write-in Ballot." See 230:30-15-4.~~

(7) Mail the prepared packet, with the ballot, to the voter.

(b) When an application for a state write-in absentee ballot is received from a uniformed services voter or an overseas voter, and when the voter has requested to receive the state write-in absentee ballot by electronic mail, the procedure outlined in 230:30-9-5.2 shall be observed to transmit the ballot and related balloting materials listed in (a) ~~(6)-(5)~~ of this Section by electronic mail.

## 230:30-15-6. List of candidates

The State Election Board will provide each County Election Board with a list of candidates for each statewide or federal office on the ~~ballots ballot~~ as soon as it is available before an election. The list of candidates shall be sent either by regular or electronic mail to voters who request the state write-in absentee ballot. If the list is available when the state write-in absentee ballot is sent, it shall be sent with the ballot. If the list is not available at the time the ballot is sent, the list shall be sent to the voter as soon as it becomes available by the same method the ballot was sent.

## 230:30-15-7. Voters who request both regular and state write-in absentee ballots

Uniformed services voters and overseas voters are entitled by law to apply for both the state write-in absentee ballots and regular absentee ballots for the same election. The two requests may be made in the same application or may be made separately. If a uniformed services voter or an overseas voter requests both regular and state write-in absentee ballots, the state write-in absentee ballot shall be mailed in one set of absentee envelopes as outlined in 230:30-15-5, and the regular absentee ballots shall be mailed in a separate set of absentee envelopes as outlined in 230:30-9-2. The request for regular ballots shall be processed as outlined in 230:30-9-5. In the event that a voter requests that the state write-in absentee ballot be transmitted by electronic mail, the ballot shall be sent according to the procedure outlined in 230:30-9-5.2 and the state write-in absentee ballot shall not be sent by regular mail.

## 230:30-15-9. Rules for counting state write-in absentee ballots

A state write-in absentee ballot shall be opened and counted only if regular absentee ballots from the voter are not received prior to 7 p.m. election day, except for the Runoff Primary Election. See 230:30-19-15. If regular absentee ballots are received from the voter prior to 7 p.m. election day, those

regular absentee ballots shall be counted and the state write-in absentee ballots shall be rejected without being opened. If only the state write-in absentee ballot is received by the County Election Board prior to 7 p.m. election day, it shall be opened and shall be counted, provided that the affidavit is properly executed. When counting state write-in absentee ballots, the following provisions shall be observed:

- (1) The requirements for the affidavit are the same as those for a regular absentee ballot from a military uniformed services voter or an overseas voter. See 230:30-9-5.
- (2) The voter may write in the names of specific candidates or the names of ~~persons whom the party that the~~ voter prefers.
- (3) In the General Election, the voter may write in a party preference for each office.
- (4) State write-in absentee ballots shall be counted ~~by hand by the County Election Board Chairman and Vice Chairman~~ as outlined in 230:30-19-6.

*[OAR Docket #10-1230; filed 10-19-10]*

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

*[OAR Docket #10-1224]*

**RULEMAKING ACTION:**  
EMERGENCY adoption

**RULES:**

- Subchapter 5. Individual Providers and Specialties
- Part 75. Federally Qualified Health Centers
- 317:30-5-660.1. [AMENDED]
- 317:30-5-660.3. through 317:30-5-660.4. [AMENDED]
- 317:30-5-661.1. [AMENDED]
- 317:30-5-661.5. [AMENDED]
- 317:30-5-661.7. [AMENDED]
- 317:30-5-664.5. [AMENDED]
- 317:30-5-664.7. [AMENDED]
- 317:30-5-664.10. [AMENDED]
- 317:30-5-664.11. [REVOKED]

**(Reference APA WF # 10-04)**

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR §405.2400 through §405.2472.

**DATES:**

**Adoption:**

August 25, 2010

**Approved by Governor:**

October 14, 2010

**Effective:**

Immediately upon Governor's approval

**Expiration:**

Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature

**SUPERSEDED EMERGENCY ACTIONS:**

N/A

**INCORPORATIONS BY REFERENCE:**

N/A

**FINDING OF EMERGENCY:**

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency

approval of rule revisions to amend policy to clarify reimbursement for certain Licensed Behavioral Health Professionals (LBHP) in Federally Qualified Health Centers (FQHC). Additionally, revisions are made to reflect contracting and reimbursement requirements for covered services in FQHC's and school settings. Policy revisions are needed to make certain LBHP's who provide behavioral health services in FQHC's are reimbursed appropriately. Revisions are also needed to identify behavioral health services that are permissible in FQHC's and school settings. These revisions ensure that the reimbursement rates for services rendered in FQHC's comply with cost based reimbursement accounting principles thereby eliminating payment errors and guarding the Agency's Federal Financial Participation from being at risk.

**ANALYSIS:**

Rules are being revised to clarify reimbursement methods for providers of FQHC's and their relationship to the Prospective Payment System (PPS) rate. Currently, rules are not clear as to which providers would be reimbursed the PPS rate or the Fee-for-service rate for services provided. Additionally, rules are revised to clarify requirements for FQHC contracting and behavioral health services provided in school settings.

**CONTACT PERSON:**

Tywanda Cox at (405)522-7153

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS  
AND SPECIALTIES**

**PART 75. FEDERALLY QUALIFIED HEALTH  
CENTERS**

**317:30-5-660.1. Health Center multiple sites contracting**

(a) Health Centers may contract as SoonerCare Traditional providers and as a PCP/CM under SoonerCare Choice (Refer to OAC 317:25-7-5).

(b) Health Centers are required to submit a list of all entities affiliated or owned by the Center including any programs that do not have Health Center status, along with all OHCA provider numbers.

(c) Payment for FQHC services is based on a Prospective Payment System (PPS). (Refer to OAC 317:30-5-664.10) In order to be eligible for reimbursement under this method for covered services, in traditional primary care settings, each site must submit an approval copy of the Health Resource and Service Administration (HRSA) Notice of Grant Award Authorization for Public Health Services Funds under Section 330, (or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC) and a copy of the Medicare certification number, at the time of enrollment.

**317:30-5-660.3. Health Center enrollment requirements for ~~other~~ specialty behavioral health services**

(a) For the provision of behavioral health related case management services, Health Centers must meet the requirements found at ~~OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599.~~

## Emergency Adoptions

(b) For the provision of psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-240 through 30-5-249.

(c) Health Centers which provide substance abuse treatment services must also ~~have a contract be certified by with~~ the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

### **317:30-5-660.4. Health Center enrollment requirements for school-based health services in a school setting**

~~(a) For the provision of school-based health Physical and behavioral health services provided in accordance with the Individuals with Disabilities Education Act (IDEA) and pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) are the responsibility of the school district. (not a health care delivery site), Health Centers must be contracted contract with a qualified school provider. the school district and invoice the school district for services rendered. (Refer to OAC 317:30-5-1020 through 30-5-1027). Reimbursement is made directly to the school.~~

~~(b) Payment may be made for FQHC services to Health Centers that have a health care delivery site in a school setting (i.e., the school has no responsibility under IDEA /no contract with OHCA and a parental authorization must be on file) and that have a HRSA Grant Award Authorization or "look alike" designation.~~

### **317:30-5-661.1. Health Center core services**

Health Center "core" services include:

- (1) Physicians' services and services and supplies incident to a physician's services;
- (2) Services of advanced practice nurse (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
- (3) Services and supplies incident to the services of APNs, nurse midwives, and PAs;
- (4) Visiting nurse services to the homebound;
- (5) ~~Mental health professional services~~ Services of Licensed Psychologists and Licensed Clinical Social Workers (LCSWs) and services and supplies incident to the services of ~~MHPs~~ licensed psychologists and LCSWs;
- (6) Preventive primary care services;
- (7) Preventive primary dental services.

### **317:30-5-661.5. Health Center preventive primary care services**

(a) Preventive primary care services are those health services that:

- (1) a Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;
- (2) are furnished by or under the direct supervision of an APN, PA, CNMW, specialized advanced practice nurse practitioner, ~~MHP~~ licensed psychologist, LCSW, or a physician;

- (3) are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and
- (4) includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

- (1) medical social services;
- (2) nutritional assessment and referral;
- (3) preventive health education;
- (4) children's eye and ear examinations;
- (5) prenatal and post-partum care;
- (6) perinatal services;
- (7) well child care, including periodic screening (refer to OAC 317:30-3-65);
- (8) immunizations, including tetanus-diphtheria booster and influenza vaccine;
- (9) voluntary family planning services;
- (10) taking patient history;
- (11) blood pressure measurement;
- (12) weight;
- (13) physical examination targeted to risk;
- (14) visual acuity screening;
- (15) hearing screening;
- (16) cholesterol screening;
- (17) stool testing for occult blood;
- (18) dipstick urinalysis;
- (19) risk assessment and initial counseling regarding risks;
- (20) tuberculosis testing for high risk patients;
- (21) clinical breast exam;
- (22) referral for mammography;
- (23) thyroid function test; and
- (24) dental services (specified procedure codes).

### **317:30-5-661.7. Off-site Allowable Places of services**

~~(a) Off-site Services means services provided to members within the four walls of the at a location other than the Center. Off site services are considered Health Center services if the physician's or other practitioner's agreement requires that he or she seek reimbursement from the Health Center. Health Center and approved Health Center satellites including mobile health clinics operated by the Center are allowable for reimbursement under the PPS. Off site services include services provided at mobile health clinics operated by the Center. Services provided by Centers in school settings (i.e., the school has no responsibility/no contract with OHCA and a parental authorization must be on file) are considered off site services.~~

~~(b) Medically necessary Health Center services provided off site or outside of the Health Center setting are compensable when billed by the Center. The Health Center must have a written contract with the physician and other Center core practitioners that specify that Center services provided off site will be billed to Medicaid and, how such providers will be compensated. It is expected that services provided in off site settings should be, in most cases, temporary and intermittent.~~

~~i.e., when the member cannot come to the clinic due to health reasons.~~

~~(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Center. Off-site behavioral health services must take place in a confidential setting.~~

(b) Off-site services provided by employed practitioners of the Health Center to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the Health Center for health care are also allowable for reimbursement under the PPS encounter rate if the service would be reimbursed the PPS at the Center. It is expected that services provided in off-site settings should be, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

**317:30-5-664.5. Health Center encounter exclusions and limitations**

(a) Service limitations governing the provision of all services apply pursuant to OAC 317:30. Excluded from the definition of reimbursable encounter core services are:

- (1) Services provided by an independently CLIA certified and enrolled laboratory.
- (2) Radiology services including nuclear medicine and diagnostic ultrasound services.
- (3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a client member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.
- (4) Durable medical equipment or medical supplies not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.
- (5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.
- (6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a client member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.
- (7) Administrative medical examinations and report services;
- (8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;
- (9) Family planning services provided to individuals enrolled in the Family Planning Waiver;
- (10) Optometry and podiatric services other than for dual eligible for Part B of Medicare;

~~(40 11) Other services that are not defined in this rule or the State Plan.~~

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

- ~~(1) Physician services are not covered in a hospital.~~
- ~~(2) Encounters for PCP/CM covered capitated services provided to eligible SoonerCare Choice members enrolled in the Health Center's panel (except family planning services or HIV/AIDS prevention services) are not reimbursed as an encounter. However, PCP/CM covered services are included in the PPS wrap-around/reconciliation process (refer to OAC 317:30-5-664.11 for specific details).~~
- ~~(3 2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240, 317:30-5-585, and 317:30-5-595 and contracted with OHCA as an outpatient behavioral health agency.~~
- ~~(4 3) Behavioral health services are limited to those services furnished to members at or on behalf of the Health Center.~~

**317:30-5-664.7. Dental services provided by Health Centers**

~~(a) Covered medically necessary preventive dental services provided to adults and children are considered core services.~~

(a) **General.** Medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician are considered core services.

(b) **Adults.** The Health Center core service benefit to SoonerCare Traditional and SoonerCare Choice adults is intended to provide services requiring immediate treatment, relief of pain and/or extraction and is not intended to restore teeth. For scope of services for individuals eligible under other program categories, refer to OAC 317:30-5-696. ~~Core Services~~ services are limited to treatment for conditions such as:

- (1) Acute infection;
- (2) Acute abscesses;
- (3) Severe tooth pain; and
- (4) Tooth re-implantation, when clinically appropriate.

~~(e) Other medically necessary dental services which are not considered to be preventive may be billed by the Health Center utilizing the current SoonerCare fee schedule.~~

(c) **Children.** Medically necessary dental services for children are covered.

(d) **Exclusions and Limitations.** Other medically necessary dental services which are not considered core services may be billed by the Health Center utilizing the current SoonerCare fee schedule.

- (1) Emergency Extractions are limited to three per day;
- (2) Smoking and tobacco use cessation is a covered service for adults and children.
- (3) Refer to OAC 317:30-5-695 for other specific coverage, exclusions and prior authorization requirements.

## Emergency Adoptions

(~~e~~) Health Centers must submit all claims for SoonerCare reimbursement for dental services on the American Dental Association (ADA) form.

### 317:30-5-664.10. Health Center reimbursement

(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, ~~effective January 1, 2002~~, reimbursement is provided for core services, primary behavioral health and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) determined according to the methodology described in OAC 317:30-5-664.12.

(b) As claims/encounters are filed, reimbursement for SoonerCare Choice and SoonerCare Traditional members is made for all medically necessary covered primary care services ~~(that are not included in the SoonerCare capitation payment, if applicable)~~ and other health services at the ~~current rate for that CPT/HCPCS code~~ PPS rate.

(~~c~~) As claims are filed, reimbursement for SoonerCare Traditional members is made for all medically necessary covered ~~primary care and other health services at the PPS rate.~~

(~~c~~) The originating site facility fee for telemedicine services is not a Federally Qualified Health Center (FQHC) service. When a FQHC serves as the originating site, the originating site facility fee is paid separately from the center's all-inclusive rate.

(d) Primary and preventive behavioral health services rendered by core providers will be reimbursed at the PPS encounter rate.

(e) Non-Core LBHP behavioral health services are reimbursed according to the SoonerCare fee-for-service fee schedule with a maximum of 8 sessions per member per month and 8 units of testing per member per year.

(f) Vision services provided by Optometrists within the scope of their licensure for non dual eligible members and allowed under the Medicaid State Plan are reimbursed pursuant to the SoonerCare fee-for-service fee schedule.

### 317:30-5-664.11. PPS rate reconciliation to Health Centers [REVOKED]

(a) ~~PPS reconciliation/wrap around adjustments will be made for the difference in the facility specific PPS rate and the fee schedule payments.~~

(b) ~~OHCA compares the total payments due under the PPS rate per visit method and the payments made under the methods described in OAC 317:30-5-664.10 (b) and (c).~~

(c) ~~OHCA will make an adjustment for the difference in the payments allowed and the facility specific PPS rate. The difference in payments will be reconciled not less often than quarterly.~~

*[OAR Docket #10-1224; filed 10-18-10]*

## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 45. INSURE ~~OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE~~

*[OAR Docket #10-1225]*

### RULEMAKING ACTION:

EMERGENCY adoption

### RULES:

Subchapter 13. Insure Oklahoma Dental Services [NEW]  
317:45-13-1. [NEW]

(Reference APA WF # 10-32)

### AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes

### DATES:

#### Adoption:

August 25, 2010

#### Approved by Governor:

October 14, 2010

### Effective:

Immediately upon Governor's approval

### Expiration:

Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature

### SUPERSEDED EMERGENCY ACTIONS:

N/A

### INCORPORATIONS BY REFERENCE:

N/A

### FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Insure Oklahoma program to comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes and the requirements set forth in the Children's Health Insurance Program Reauthorization Act of 2009. Rules are revised to add dental services requirements and benefits for children. The OHCA will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP) program. Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. This expansion to the Insure Oklahoma program will increase access to health care for Oklahoma children, thereby reducing the amount of uncompensated care provided by health care providers.

### ANALYSIS:

Insure Oklahoma rules are revised to add dental services requirements and benefits for children. The Oklahoma Health Care Authority (OHCA), as a requirement of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule.

### CONTACT PERSON:

Tywanda Cox at (405)522-7153

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

**SUBCHAPTER 13. INSURE OKLAHOMA  
DENTAL SERVICES**

**317:45-13-1. Dental services requirements and benefits**

The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Dental coverage is obtained through direct purchase from the OHCA. The existing cost sharing requirements for IP qualified children apply. Children obtaining medical coverage through IP receive Dental IP coverage. The OHCA contracts with Dental IP providers utilizing the SoonerCare network. The Dental IP providers are reimbursed pursuant to the SoonerCare fee schedule for rendered services.

- (1) The Dental IP program is covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage is provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Prior authorization is required for certain services.
- (2) Class A services are covered as medically necessary and include preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay is required.
- (3) Class B services are covered as medically necessary and include basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, \$10 co-pay is required.
- (4) Class C services are covered as medically necessary and include major, prosthodontic care such as crowns, bridges and dentures, \$25 co-pay is required.
- (5) Class D services are covered as medically necessary and include orthodontic care. Orthodontic care is not covered for cosmetic purposes or any purposes which are not medical in nature, \$25 co-pay is required.
- (6) Emergency dental services are covered as medically necessary, no co-pay is required.

[OAR Docket #10-1225; filed 10-18-10]

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

[OAR Docket #10-1227]

**RULEMAKING ACTION:**  
EMERGENCY adoption

**RULES:**

Subchapter 3. My Life, My Choice [NEW]  
317:50-3-1. through 317:50-3-16. [NEW]  
(Reference APA WF # 10-41)

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

**DATES:**

**Adoption:**

August 25, 2010

**Approved by Governor:**

October 14, 2010

**Effective:**

Immediately upon Governor's approval

**Expiration:**

Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature

**SUPERSEDED EMERGENCY ACTIONS:**

N/A

**INCORPORATIONS BY REFERENCE:**

N/A

**FINDING OF EMERGENCY:**

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to include language allowing for a new Home and Community Based Services Waiver program known as My Life, My Choice. The My Life, My Choice Waiver is targeted to members who are 20 to 64 years of age, are physically disabled and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care, therefore, a substantial savings will be realized over time through operation of this Waiver.

**ANALYSIS:**

Rules are revised to include language allowing for a new Home and Community Based Services Waiver program. The My Life, My Choice Waiver is targeted to members who are 20 to 65 years of age, have a physical disability and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new waiver allows members to continue receiving the same home and community based services offered through Living Choice.

**CONTACT PERSON:**

Tywanda Cox at (405)522-7153

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

**SUBCHAPTER 3. MY LIFE, MY CHOICE**

**317:50-3-1. Purpose**

The My Life, My Choice Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for a targeted group of physically disabled individuals. To be considered for My Life, My Choice Waiver Program services, individuals must meet the basic criteria set forth under 317:50-3-3.

**317:50-3-2. Definitions**

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

"ADL" means the activities of daily living. Activities of daily living are activities that reflect the member's ability

## Emergency Adoptions

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to perform self-care tasks essential for sustaining health and safety such as:

- (A) bathing.
- (B) eating.
- (C) dressing.
- (D) grooming.
- (E) transferring (includes getting in and out of a tub, bed to chair, etc.).
- (F) mobility.
- (G) toileting, and
- (H) bowel/bladder control.

**"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

**"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

**"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

**"Developmental Disability"** means a severe, chronic disability of an individual that:

- (A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (B) is manifested before the individual attains age 22;
- (C) is likely to continue indefinitely;
- (D) results in substantial functional limitations in three or more of the following areas of major life activity:
- (E) self-care;
- (F) receptive and expressive language;
- (G) learning;
- (H) mobility;
- (I) self-direction;
- (J) capacity for independent living;
- (K) economic self-sufficiency; and
- (L) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of life-long or extended duration and is individually planned and coordinated.

**"Environment high risk"** means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

**"Environment moderate risk"** means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

**"Health Assessment high risk"** means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

**"Health Assessment low risk"** means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the My Life, My Choice program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

**"Health Assessment moderate risk"** means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

**"IADL"** means the instrumental activities of daily living.

**"IADLs score in high risk range"** means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

**"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- (A) shopping.
- (B) cooking.
- (C) cleaning.
- (D) managing money.
- (E) using a telephone.
- (F) doing laundry.
- (G) taking medication, and
- (H) accessing transportation.

**"Member Support high risk"** means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, very little or no support is available from informal and

formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

**"Member Support moderate risk"** means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

**"Mental Retardation"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

**"MSQ"** means the mental status questionnaire.

**"MSQ score in high risk range"** means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

**"MSQ score at the high end of the moderate risk range"** means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

**"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

**"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

**"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

**317:50-3-3. My Life, My Choice program overview**

(a) The My Life, My Choice program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for a targeted group of physically disabled adults. My Life, My Choice services are outside the scope of state plan Medicaid services. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.

(1) To be considered for My Life, My Choice services, individuals must meet the following criteria:

(A) be 20 to 64 years of age;

(B) be physically disabled; and

(C) have transitioned to a home and community based setting through the Living Choice Program;

(2) In addition, the individual must meet the following minimum UCAT criteria:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or

(II) MSQ score is at the high end of moderate risk range; or

(III) IADLs score is in the high risk range; or

(IV) Nutrition score is in the high risk range; or

(V) Health Assessment is in the moderate risk range, and, in addition:

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Individual Support is moderate risk; or

(ii) Environment is high risk; or

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-3-3(a)(2)(A) criteria if untreated; and

(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of My Life, My Choice Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

## Emergency Adoptions

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- (D) lack the ability to adequately and appropriately care for self or communicate needs to others;
- (E) require medical care and treatment in order to minimize physical health regression or deterioration;
- (F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and
- (G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.
- (4) Meet service eligibility criteria [see OAC 317:50-3-3(c)].
- (5) Meet program eligibility criteria [see OAC 317:50-3-3(d)].
- (b) Services provided through the My Life, My Choice Waiver are:
  - (1) case management;
  - (2) respite;
  - (3) adult day health care;
  - (4) environmental modifications;
  - (5) specialized medical equipment and supplies;
  - (6) physical therapy;
  - (7) occupational therapy;
  - (8) respiratory therapy ;
  - (9) speech therapy;
  - (10) assistive technology;
  - (11) audiology treatment and evaluation;
  - (12) dental services and treatment up to \$1,000 annually;
  - (13) family counseling;
  - (14) family training;
  - (15) independent living skills training;
  - (16) nutrition services;
  - (17) psychiatry;
  - (18) psychological services;
  - (19) vision services;
  - (20) pharmacological evaluations;
  - (21) agency companion;
  - (22) advanced supportive/restorative assistance;
  - (23) skilled nursing and private duty nursing;
  - (24) home delivered meals;
  - (25) hospice care;
  - (26) medically necessary prescription drugs within the limits of the waiver;
  - (27) personal care (state plan), or My Life, My Choice personal care;
  - (28) Personal Emergency Response System (PERS);
  - (29) Self-directed services;
  - (30) all other SoonerCare medical services within the scope of the State Plan, including SoonerRide non-emergency transportation.
- (c) A service eligibility determination is made using the following criteria:
  - (1) an open My Life, My Choice Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid

Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all My Life, My Choice Waiver slots are filled, the individual cannot be certified as eligible for My Life, My Choice Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. My Life, My Choice Waiver slots and corresponding waiting lists, if necessary, are maintained.

- (2) the individual is in the My Life, My Choice Waiver targeted service group. The target group is an individual who is age 20 to 64 with a physical disability.
- (3) the individual does not pose a physical threat to self or others as supported by professional documentation.
- (4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.
- (d) The My Life, My Choice Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:
  - (1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through My Life, My Choice Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of My Life, My Choice Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.
  - (2) if the individual poses a physical threat to self or others as supported by professional documentation.
  - (3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.
  - (4) if the individual's needs are being met, or do not require My Life, My Choice Waiver services to be met, or if the individual would not require institutionalization if needs are not met.
  - (5) if, after the service plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.
- (e) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the My Life, My Choice Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.

(f) Individuals determined ineligible for My Life, My Choice Waiver program services are notified in writing of the determination and of their right to appeal the decision.

### **317:50-3-4. Application for My Life, My Choice Waiver services**

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the My Life, My Choice Waiver. In order to transition from the Living Choice demonstration program to the My Life, My Choice Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the My Life, My Choice Waiver. The original application and eligibility processes are set forth in 317:50-3-4(a)(1) through 317:50-3-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for My Life, My Choice Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the My Life, My Choice waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate.

However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **My Life, My Choice Waiver waiting list procedures.** My Life, My Choice Waiver Program "available capacity in the month" is the number of additional members that may be enrolled in the Program in a given month without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year.

### **317:50-3-5. My Life, My Choice Waiver program medical eligibility determination**

A medical eligibility determination is made for My Life, My Choice Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require My Life, My Choice Waiver Program, or NF level services to assure member health and safety. My Life, My Choice Waiver services are designed to be a continuation of support for the informal care that is being provided in the member's home. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, My Life, My Choice Waiver service provision will supplement the system within the limitations of My Life, My Choice Waiver Program policy.

(1) Categorical relationship must be established for determination of eligibility for My Life, My Choice Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) If the UCAT indicates member qualification for SoonerCare services and the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(4) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

## Emergency Adoptions

(5) Within ten (10) working days of receipt of a complete My Life, My Choice Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria.

(6) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the My Life, My Choice Waiver Program.

(7) If the member has a current certification and requests a change to My Life, My Choice Waiver services, a new UCAT is required. The UCAT is also updated when a member requests a change from My Life, My Choice Waiver services to State Plan Personal Care services. If a member is receiving My Life, My Choice Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(8) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

### **317:50-3-6. Determining financial eligibility for the My Life, My Choice Waiver program**

Financial eligibility for My Life, My Choice Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the My Life, My Choice Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the My Life, My Choice Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in My Life, My Choice Waiver Program services is as follows:

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for My Life, My Choice Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for My Life, My Choice Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBW program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of My Life, My Choice Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for My Life, My Choice Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

**(B) Resource eligibility.** In order for an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for the My Life, My Choice Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

**(C) Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

**(3) Individual with a spouse in the home who is not in a Home and Community Based Waiver Program.**

When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in My Life, My Choice Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

**(A) Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the My Life, My Choice Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

**(B) Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the My Life, My Choice Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving My Life, My Choice Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving My Life, My Choice program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the My Life, My Choice Waiver program (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of

## Emergency Adoptions

the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving My Life, My Choice Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving My Life, My Choice Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII, D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the My Life, My Choice Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving My Life, My Choice Waiver program

services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost (\$2,000) to a private patient in an NF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;



## Emergency Adoptions

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(D) The penalty period:

- (i) cannot begin until the expiration of any existing period of ineligibility;
- (ii) will not be interrupted or temporarily suspended once it is imposed;
- (iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

- (i) Separate Maintenance or Divorce.
  - (I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.
  - (II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.
  - (III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.
  - (IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or

resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

- (v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.
- (vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.
- (vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.
- (I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.
- (II) Such determination should be referred to OKDHS State Office for a decision.
- (III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.
- (I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of My Life, My Choice Waiver program services and the continuance of eligibility for other SoonerCare services.
- (J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.
- (K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.
- (L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for My Life, My Choice Waiver program services for a period of asset ineligibility.
- (M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.
- (i) Documentation must be provided to show each co-owner's contribution;
- (ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.
- (N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.
- (6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.
- 317:50-3-7. Certification for My Life, My Choice Waiver program services**
- (a) **Financial certification period for My Life, My Choice Waiver program services.** The financial certification period for the My Life, My Choice Waiver program is 12 months.
- (b) **Medical Certification period for My Life, My Choice Waiver program services.** The medical certification period for My Life, My Choice Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.
- 317:50-3-8. Redetermination of eligibility for My Life, My Choice Waiver services**
- A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.
- 317:50-3-9. Member annual level of care re-evaluation and annual re-authorization of service plan**
- (a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress

## Emergency Adoptions

of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.

(b) At a maximum of every 11 months, the case manager makes a home visit to evaluate the My Life, My Choice Waiver member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process.

(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the member is evaluated for the continued need for Nursing Facility level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's "medical eligibility end date" is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for My Life, My Choice Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of My Life, My Choice Waiver services.

### **317:50-3-10. My Life, My Choice Waiver services during hospitalization or nursing facility placement**

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date

the case manager notifies relevant providers and coordinates the resumption of My Life, My Choice Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's case manager expedites the restart of My Life, My Choice Waiver services for the member.

### **317:50-3-11. Closure or termination of My Life, My Choice Waiver services**

(a) **Voluntary closure of My Life, My Choice Waiver services.** If the member requests a lower level of care than My Life, My Choice Waiver services or if the member agrees that My Life, My Choice Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility.** The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility.** Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for My Life, My Choice Waiver services, the individual and provider are notified of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:50-3-3(d).

(d) **Resumption of My Life, My Choice Waiver services.** If a member approved for My Life, My Choice Waiver services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after 90 days, the member must request the services.

### **317:50-3-12. Eligible providers**

My Life, My Choice Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file.

(1) The provider programmatic certification process verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to My Life, My Choice Program Conditions of Participation. Providers must obtain programmatic certification to be My Life, My Choice Program certified.

(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.

(3) Providers may fail to gain or may lose Waiver Program certification due to failure to meet either programmatic or financial standards.

(4) At a minimum, provider financial certification is reevaluated annually.

(5) Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and NF Respite services do not have a programmatic evaluation after the initial certification.

(6) OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the My Life, My Choice Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved Waiver document;

(ii) be necessary to avoid institutionalization;

(iii) be a service/support that is specified in the individual service plan;

(iv) be provided by a person who meets the provider qualifications and training standards specified in the Waiver for that service;

(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the OHCA for the payment of personal care or personal assistance services;

(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

(i) not provide more than 40 hours of services in a seven day period;

(ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;

(iii) maintain and submit time sheets and other required documentation for hours paid; and

(iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and

(ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.

(7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider Plan of Correction is required, the OHCA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

## Emergency Adoptions

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### **317:50-3-13. Coverage**

Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved plan of care. Any My Life, My Choice Program service provided must be listed on the approved plan of care and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.

(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to My Life, My Choice Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.

(2) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.

(3) The member may request to Self-Direct their services from their Case Manager or call the My Life, My Choice Program toll-free number to request the Self-Directed Services option.

### **317:50-3-14. Description of services**

Services included in the My Life, My Choice Program are as follows:

#### **(1) Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet My Life, My Choice Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior

to providing services to members choosing to Self-Direct their services. Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-3-14(1)(A) that only a My Life, My Choice case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

#### **(2) Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the

plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

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

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

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

**(3) Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

**(4) Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

**(5) Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which

require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

**(6) Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services include skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the My Life, My Choice Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing

## Emergency Adoptions

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tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(7) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(8) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(9) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the

member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

**(10) Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(11) Respiratory Therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services

are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(12) Hospice services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for My Life, My Choice Facility Based Extended Respite. Hospice provided as part of Facility Based Extended respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice

## Emergency Adoptions

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provided as a Medicare Part A benefit, is not eligible to receive My Life, My Choice Hospice services.

(B) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the member or member's family.

(13) **My Life, My Choice Waiver Personal Care.**

(A) My Life, My Choice Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) My Life, My Choice Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) My Life, My Choice Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

(14) **Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member. Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.

(15) **Assistive Technology.** Assistive technology enables the member to maintain or increase functional capabilities. Assistive technology devices are in addition to equipment and supplies readily available through traditional State Plan services and exclude items that are not of direct medical or remedial benefit to the member. Assistive technology includes the purchase, rental, customization, maintenance and repair of such devices.

(16) **Audiology Treatment and Evaluation.** Services include evaluation, treatment and consultation related to auditory functioning and are intended to maximize the member's hearing abilities.

(17) **Agency Companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(18) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not

exceed \$1,000 per plan year of care. These services may include:

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(19) **Family Training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(20) **Family Counseling.** Family counseling helps to develop and maintain healthy, stable relationships among all family members in order to support meeting the needs of the member. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home. Services are intended to maximize the member/family's emotional/social adjustment and well-being. All family counseling needs are documented in the member's plan of care. Individual counseling cannot exceed 400, 15-minute units per plan of care year. Group counseling cannot exceed 225, 30-minute units per plan of care year. Case Managers assist the member to identify other alternatives to meet identified needs above the limit.

(21) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(22) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids,

determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(23) **Independent Living Skills training.** Independent living skills training is a service to support the individual's self care, daily living, adaptive skills and leisure skills needed to reside successfully in the community. Services are provided in community based settings in a manner that contributes to the individual's independence, self sufficiency, community inclusion and well being. This service is intended to train members with significant cognitive problems living skills such as selecting clothing, dressing, and personal shopping.

(24) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For a My Life, My Choice Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

- (i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
- (v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
- (vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the My Life, My Choice approved plan of care.

(25) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically

necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(26) **Psychiatry.** Psychiatry provides outpatient psychiatric services provided by a licensed psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in recognition of psychiatric illness and adverse reactions to medications.

(27) **Psychological services.** Psychological services include evaluation, psychotherapy, consultation and behavioral treatment. Services are provided in any community setting as specified in the member's service plan. Services are intended to maximize the member's psychological and behavioral well-being. Services are provided in both individual and group (8 person maximum) formats. The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.

(28) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

(29) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.

(30) **Self-Direction.**

## Emergency Adoptions

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(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

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

(i) residence in the Self-Directed services approved area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

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

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no

longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

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

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the

employment complies with State and Federal Labor Law requirements. The member:

- (i) recruits, hires and, as necessary, discharges the PSA and APSA;
- (ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;
- (iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;
- (iv) supervises and documents employee work time; and,
- (v) provides tools and materials for work to be accomplished.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

- (i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
- (ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;
- (iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;
- (iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(I) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The

number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

### **317:50-3-15. Reimbursement**

Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board. Rates for Waiver services are set by one of the methodologies below:

(1) A fixed and uniform SoonerCare Rate. When a Waiver service is similar or the same as a Medicaid State Plan service for which a fee schedule has been established, the current SoonerCare rate is utilized.

# Emergency Adoptions

(2) The current Medicare rate. When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.

(3) Individual rates. Certain services because of their variables do not lend themselves to a fixed and uniform rate. Payment for these services is made on an individual basis following a uniform process approved by the OHCA.

## **317:50-3-16. Billing procedures for My Life, My Choice Waiver services**

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The approved My Life, My Choice Waiver service plan is the basis for the MMIS service prior authorization, specifying:

- (1) service;
- (2) service provider;
- (3) units authorized; and
- (4) begin and end dates of service authorization.

(c) As part of My Life, My Choice Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

*[OAR Docket #10-1227; filed 10-18-10]*

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

*[OAR Docket #10-1226]*

### **RULEMAKING ACTION:**

EMERGENCY adoption

### **RULES:**

Subchapter 5. Sooner Seniors [NEW]  
317:50-5-1. through 317:50-5-16. [NEW]  
(Reference APA WF # 10-40)

### **AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

### **DATES:**

#### **Adoption:**

August 25, 2010

#### **Approved by Governor:**

October 14, 2010

#### **Effective:**

Immediately upon Governor's approval

#### **Expiration:**

Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature

#### **SUPERSEDED EMERGENCY ACTIONS:**

N/A

#### **INCORPORATIONS BY REFERENCE:**

N/A

#### **FINDING OF EMERGENCY:**

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to include language allowing for a new Home and Community Based Services Waiver program known as Sooner Seniors. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care, therefore, a substantial savings will be realized over time through operation of this Waiver.

#### **ANALYSIS:**

Rules are revised to include language allowing for a new Home and Community Based Services Waiver. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new waiver allows members to continue receiving the same home and community based services offered through Living Choice.

#### **CONTACT PERSON:**

Tywanda Cox at (405)522-7153

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

## **SUBCHAPTER 5. SOONER SENIORS**

### **317:50-5-1. Purpose**

The Sooner Seniors Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for a targeted group of elderly individuals. To be considered for Sooner Seniors Waiver Program services, individuals must meet all criteria set forth under 317:50-5-3.

### **317:50-5-2. Definitions**

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

"ADL" means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

- (A) bathing,

- (B) eating,
- (C) dressings,
- (D) grooming,
- (E) transferring (includes getting in and out of a tub, bed to chair, etc.).
- (F) mobility,
- (G) toileting, and
- (H) bowel/bladder control.

**"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

**"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

**"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

**"Environment high risk"** means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

**"Environment moderate risk"** means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

**"Health Assessment high risk"** means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

**"Health Assessment low risk"** means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the Sooner Seniors program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

**"Health Assessment moderate risk"** means member's UCAT Health Assessment score is 15 which indicates in the

UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

**"IADL"** means the instrumental activities of daily living.

**"IADLs score in high risk range"** means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

**"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- (A) shopping,
- (B) cooking,
- (C) cleaning,
- (D) managing money,
- (E) using a telephone,
- (F) doing laundry,
- (G) taking medication, and
- (H) accessing transportation.

**"Member Support high risk"** means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

**"Member Support moderate risk"** means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

**"Mental Retardation"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

**"MSQ"** means the mental status questionnaire.

**"MSQ score in high risk range"** means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

**"MSQ score at the high end of the moderate risk range"** means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

## Emergency Adoptions

"Nutrition high risk" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

"Social Resources high risk" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

### 317:50-5-3. Sooner Seniors program overview

(a) The Sooner Seniors program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for a targeted group of elderly adults. Sooner Seniors services are outside the scope of state plan Medicaid services. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.

(1) To be considered for Sooner Seniors services, individuals must meet the following criteria:

(A) be age 65 years or older;

(B) have a clinically documented, progressive degenerative disease process that responds to treatment and requires Sooner Seniors Waiver services to maintain the treatment regimen to prevent health deterioration and remain in a home and community based setting;

(C) have transitioned to a home and community based setting through the Living Choice Program;

(2) In addition, the individual must meet the following minimum UCAT criteria:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or

(II) MSQ score is at the high end of moderate risk range; or

(III) IADLs score is in the high risk range; or

(IV) Nutrition score is in the high risk range; or

(V) Health Assessment is in the moderate risk range, and, in addition:

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Individual Support is moderate risk; or

(ii) Environment is high risk; or

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-5-3(a)(2)(A) criteria if untreated; and

(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of Sooner Seniors Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) NF Level of Care Services. To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

(4) Meet service eligibility criteria [see OAC 317:50-5-3(c)].

(5) Meet program eligibility criteria [see OAC 317:50-5-3(d)].

(b) Services provided through the Sooner Seniors Waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

- (5) specialized medical equipment and supplies;
  - (6) physical therapy;
  - (7) occupational therapy;
  - (8) respiratory therapy;
  - (9) speech therapy;
  - (10) dental services and treatment up to \$1,000 annually;
  - (11) family training services;
  - (12) nutritional education services;
  - (13) vision services;
  - (14) pharmacological evaluations;
  - (15) agency companion;
  - (16) advanced supportive/restorative assistance;
  - (17) skilled nursing and private duty nursing;
  - (18) home delivered meals;
  - (19) hospice care;
  - (20) medically necessary prescription drugs within the limits of the waiver;
  - (21) personal care (state plan), Sooner Seniors personal care;
  - (22) Personal Emergency Response System (PERS);
  - (23) Self-directed services;
  - (24) All other SoonerCare medical services within the scope of the State Plan, including SoonerRide non-emergency transportation.
- (c) A service eligibility determination is made using the following criteria:
- (1) an open Sooner Seniors Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Sooner Seniors Waiver slots are filled, the individual cannot be certified as eligible for Sooner Seniors Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. Sooner Seniors Waiver slots and corresponding waiting lists, if necessary, are maintained.
  - (2) the individual is in the Sooner Seniors Waiver targeted service group. The target group is an individual who is age 65 or older with a chronic medical condition.
  - (3) the individual does not pose a physical threat to self or others as supported by professional documentation.
  - (4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.
- (d) The Sooner Seniors Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:
- (1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through Sooner Seniors Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Sooner Seniors Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.
  - (2) if the individual poses a physical threat to self or others as supported by professional documentation.
  - (3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.
  - (4) if the individual's needs are being met, or do not require Sooner Seniors Waiver services to be met, or if the individual would not require institutionalization if needs are not met.
  - (5) if, after the service plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.
- (e) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Sooner Seniors Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.
- (f) Individuals determined ineligible for Sooner Seniors Waiver program services are notified in writing of the determination and of their right to appeal the decision.

### **317:50-5-4. Application for Sooner Seniors Waiver services**

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the Sooner Seniors Waiver. In order to transition from the Living Choice demonstration program to the Sooner Seniors Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the Sooner Seniors Waiver. The original application and eligibility processes are set forth in 317:50-5-4(a)(1) through 317:50-5-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Sooner Seniors Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(A) All conditions of financial eligibility must be verified and documented in the case record. When

## Emergency Adoptions

current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the Sooner Seniors waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **Sooner Seniors Waiver waiting list procedures.** Sooner Seniors Waiver Program "available capacity in the month" is the number of additional members that may be enrolled in the Program in a given month without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year.

### **317:50-5-5. Sooner Seniors Waiver program medical eligibility determination**

A medical eligibility determination is made for Sooner Seniors Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require Sooner Seniors Waiver Program, or NF level services to assure member health and safety. Sooner Seniors Waiver services are designed to be a continuation of support for the informal care that is being provided in the member's home. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Sooner Seniors Waiver service provision

will supplement the system within the limitations of Sooner Seniors Waiver Program policy.

(1) Categorical relationship must be established for determination of eligibility for Sooner Seniors Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) If the UCAT indicates member qualification for SoonerCare services and the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(4) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(5) Within ten (10) working days of receipt of a complete Sooner Seniors Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria

(6) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the Sooner Seniors Waiver Program.

(7) If the member has a current certification and requests a change to Sooner Seniors Waiver services, a new UCAT is required. The UCAT is also updated when a member requests a change from Sooner Seniors Waiver services to State Plan Personal Care services. If a member is receiving Sooner Seniors Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(8) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

### **317:50-5-6. Determining financial eligibility for the Sooner Seniors Waiver program**

Financial eligibility for Sooner Seniors Waiver services is determined using the rules on income and resources according

to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the Sooner Seniors Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Sooner Seniors Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Sooner Seniors Waiver Program services is as follows:

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Sooner Seniors Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for Sooner Seniors Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an

individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBW program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Sooner Seniors Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Sooner Seniors Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for the Sooner Seniors Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program.**

## Emergency Adoptions

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When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in Sooner Seniors Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the Sooner Seniors Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII, B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the Sooner Seniors Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving Sooner Seniors Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Sooner Seniors program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the

spouse into the Sooner Seniors Waiver program (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Sooner Seniors Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Sooner Seniors Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII, D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Sooner Seniors Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available to the community spouse;
- (III) determination of the spousal share of resource;
- (IV) the attribution of resources (amount deemed); or
- (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving Sooner Seniors Waiver program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred

and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost (\$2,000) to a private patient in an NF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

- (i) the title to the individual's home was transferred to:
  - (I) the spouse;
  - (II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security;
  - (III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or
  - (IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.
- (ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another

## Emergency Adoptions

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to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Sooner Seniors Waiver program services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

**(5) Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value

on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving Sooner Seniors program services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

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

- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.
- (G) Special Situations.
- (i) Separate Maintenance or Divorce.
- (I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.
- (II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.
- (III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.
- (IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.
- (ii) Inheritance from a spouse.
- (I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.
- (II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.
- (H) A penalty would not apply if:
- (i) the title to the individual's home was transferred to:
- (I) the spouse; or
- (II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security; or
- (III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or
- (IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.
- (ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.
- (iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.
- (iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.
- (v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.
- (vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.
- (vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.
- (I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.
- (II) Such determination should be referred to OKDHS State Office for a decision.
- (III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

## Emergency Adoptions

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(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Sooner Seniors Waiver program services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

### **317:50-5-7. Certification for Sooner Seniors Waiver program services**

(a) **Financial certification period for Sooner Seniors Waiver program services.** The financial certification period for the Sooner Seniors Waiver program is 12 months.

(b) **Medical Certification period for Sooner Seniors Waiver program services.** The medical certification period for Sooner Seniors Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.

### **317:50-5-8. Redetermination of eligibility for Sooner Seniors Waiver services**

A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.

### **317:50-5-9. Member annual level of care re-evaluation and annual re-authorization of service plan**

(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.

(b) At a maximum of every 11 months, the case manager makes a home visit to evaluate the Sooner Seniors Waiver member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process.

(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the member is evaluated for the continued need for Nursing Facility level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's "medical eligibility end date" is updated in the system. The member's

case manager is notified that the member has been determined to no longer meet medical eligibility for Sooner Seniors Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of Sooner Seniors Waiver services.

### **317:50-5-10. Sooner Seniors Waiver services during hospitalization or nursing facility placement**

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of Sooner Seniors Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's case manager expedites the restart of Sooner Seniors Waiver services for the member.

### **317:50-5-11. Closure or termination of Sooner Seniors Waiver services**

(a) **Voluntary closure of Sooner Seniors Waiver services.** If the member requests a lower level of care than Sooner Seniors Waiver services or if the member agrees that Sooner Seniors Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility.** The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility.** Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for Sooner Seniors

Waiver services, the individual and provider are notified of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:50-5-3(d).

(d) **Resumption of Sooner Seniors Waiver services.** If a member approved for Sooner Seniors Waiver services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after 90 days, the member must request the services.

### **317:50-5-12. Eligible providers**

Sooner Seniors Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file.

(1) **The provider programmatic certification process** verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to Sooner Seniors Program Conditions of Participation. Providers must obtain programmatic certification to be Sooner Seniors Program certified.

(2) **The provider financial certification process** verifies that the provider uses sound business management practices and has a financially stable business.

(3) **Providers may fail to gain or may lose Waiver Program certification** due to failure to meet either programmatic or financial standards.

(4) **At a minimum, provider financial certification** is reevaluated annually.

(5) **Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and NF Respite services** do not have a programmatic evaluation after the initial certification.

(6) **OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the Sooner Seniors Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:**

(A) **Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:**

- (i) **either no other provider is available; or**
- (ii) **available providers are unable to provide necessary care to the member; or**
- (iii) **the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.**

(B) **The service must:**

- (i) **meet the definition of a service/support as outlined in the federally approved Waiver document;**
- (ii) **be necessary to avoid institutionalization;**

## Emergency Adoptions

- (iii) be a service/support that is specified in the individual service plan;
- (iv) be provided by a person who meets the provider qualifications and training standards specified in the Waiver for that service;
- (v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the OHCA for the payment of personal care or personal assistance services;
- (vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:
  - (I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or
  - (II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or
  - (III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or
  - (IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.
- (C) The spouse or legal guardian who is a service provider will comply with the following:
  - (i) not provide more than 40 hours of services in a seven day period;
  - (ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;
  - (iii) maintain and submit time sheets and other required documentation for hours paid; and
  - (iv) be documented in the service plan as the member's care provider.
- (D) In addition to case management, monitoring, and reporting activities required for all Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the Case Manager the following:
  - (i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and

- (ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.
- (7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider Plan of Correction is required, the OHCA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.
- (8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

### **317:50-5-13. Coverage**

Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved plan of care. Any Sooner Seniors Program service provided must be listed on the approved plan of care and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.

- (1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to Sooner Seniors Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.
- (2) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.
- (3) The member may request to Self-Direct their services from their Case Manager or call the Sooner Seniors Program toll-free number to request the Self-Directed Services option.

### **317:50-5-14. Description of services**

Services included in the Sooner Seniors Program are as follows:

- (1) Case Management.
  - (A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility.

Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Sooner Seniors Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-5-14(1)(A) that only a Sooner Seniors case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these

members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

**(2) Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

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

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

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

**(3) Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

**(4) Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which

## Emergency Adoptions

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are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

**(5) Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

**(6) Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services include skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit

report will be made to the Sooner Seniors Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute

unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(7) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(8) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes

education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(9) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(10) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist.

## Emergency Adoptions

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The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(11) Respiratory therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(12) Hospice services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal

illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Sooner Seniors Facility Based Extended Respite. Hospice provided as part of Facility Based Extended respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Sooner Seniors Hospice services.

(B) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the member or member's family.

**(13) Sooner Seniors Waiver Personal Care.**

(A) Sooner Seniors Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Sooner Seniors Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Sooner Seniors Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

**(14) Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member. Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.

(15) **Agency companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(16) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed \$1,000 per plan year of care. These services may include:

- (A) oral examination;
- (B) bite-wing x-rays;
- (C) prophylaxis;
- (D) topical fluoride treatment;
- (E) development of a sequenced treatment plan that prioritizes:

- (i) elimination of pain;
  - (ii) adequate oral hygiene; and
  - (iii) restoration or improved ability to chew;
- (F) routine training of member or primary caregiver regarding oral hygiene; and
- (G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(17) **Family training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(18) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(19) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of

services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(20) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For a Sooner Seniors Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

- (i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
- (v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
- (vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Sooner Seniors approved plan of care.

(21) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(22) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

- (A) An initial medication assessment performed in conjunction with the case manager and member.
- (B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The

## Emergency Adoptions

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report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

(23) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.

(24) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

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

(i) residence in the Self-Directed services approved area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety:

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA)

service provider, or in monitoring and managing health or in preparation for emergency backup, or

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

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

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

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in

the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PSA and APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or

for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(I) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need

## Emergency Adoptions

for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

### **317:50-5-15. Reimbursement**

Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board. Rates for Waiver services are set by one of the methodologies below:

- (1) A fixed and uniform SoonerCare Rate. When a Waiver service is similar or the same as a Medicaid State Plan service for which a fee schedule has been established, the current SoonerCare rate is utilized.
- (2) The current Medicare rate. When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.
- (3) Individual rates. Certain services because of their variables do not lend themselves to a fixed and uniform rate. Payment for these services is made on an individual basis following a uniform process approved by the OHCA.

### **317:50-5-16. Billing procedures for Sooner Seniors Waiver services**

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The approved Sooner Seniors Waiver service plan is the basis for the MMIS service prior authorization, specifying:

- (1) service;
- (2) service provider;
- (3) units authorized; and
- (4) begin and end dates of service authorization.

(c) As part of Sooner Seniors Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system

when provided in the home. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

*[OAR Docket #10-1226; filed 10-18-10]*

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

*[OAR Docket #10-1240]*

### **RULEMAKING ACTION:**

EMERGENCY adoption

### **RULES:**

Subchapter 13. Reduction-in-Force  
Part 1. General Provisions for Reduction-in-Force  
530:10-13-3 [AMENDED]  
530:10-13-12 [AMENDED]  
Part 3. Reduction-in-Force Plan Requirements  
530:10-13-32 [AMENDED]

### **AUTHORITY:**

The Administrator of the Office of Personnel Management; 74 O.S., §§ 840-1.6A, 2.27C, 2.27D and 2.27E.

### **DATES:**

#### **Adoption:**

August 23, 2010.

#### **Approved by Governor:**

September 17, 2010

#### **Effective:**

Immediately upon Governor's approval.

#### **Expiration:**

Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature.

### **SUPERSEDED EMERGENCY ACTION:**

None

### **INCORPORATIONS BY REFERENCE:**

None

### **FINDING OF EMERGENCY:**

The proposed amendments to 530:10-13-3, 12 and 32 are necessary to address statutory changes that occurred during the restructuring of the Reduction-in-Force statutes in 2003, which removed nearly all references to unclassified employees, with except to a few situations. The rule amendments are needed to make rules comply with the Reduction-in-Force statutory provisions, which are being utilized more in light of budgetary shortfalls.

### **ANALYSIS:**

The proposed amendments to 530:10-13-3, 12 and 32 are necessary to address statutory changes that occurred during the restructuring of the Reduction-in-Force statutes in 2003, which removed nearly all references to unclassified employees, with except to a few situations. The rule amendments are needed to make rules comply with the Reduction-in-Force statutory provisions, which are being utilized more in light of budgetary shortfalls.

### **CONTACT PERSON:**

Kara I. Smith, General Counsel, Office of Personnel Management, 2101 N. Lincoln, G-80, Oklahoma City, OK 73105, (405) 522-1736.

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

SUBCHAPTER 13. REDUCTION-IN-FORCE

PART 1. GENERAL PROVISIONS FOR REDUCTION-IN-FORCE

530:10-13-3. Notice of reduction-in-force and time requirements

(a) Cabinet Secretary approval. Prior to the posting of any reduction-in-force notice, the notice shall be approved by the cabinet secretary for the agency conducting the reduction-in-force. [74:840-2.27C] If there is no incumbent cabinet secretary for the agency or if the appointing authority is governed by an elected official, the approval requirement shall not apply.

(b) Notice. At least 60 days before the scheduled beginning of reduction-in-force separations or as otherwise provided by law, the Appointing Authority shall post a notice in each office affected by the proposed reduction-in-force that a reduction-in-force will be conducted in accordance with the Oklahoma Personnel Act and Merit Rules. Such notice shall be posted for 5 days. The Appointing Authority shall provide a copy of the notice to the Administrator. A reduction-in-force shall not be used as a disciplinary action. [74:840-2.27C(A)]

(c) Implementation plan. The reduction-in-force implementation plan and subsequent personnel transactions directly related to the reduction-in-force shall be in compliance with rules adopted by the Administrator. The reduction-in-force implementation plan, including the description of and reasons for displacement limits and protections from displacement actions, and severance benefits that will be offered shall be posted in each office affected by the plan within 5 business days after posting of the reduction-in-force notice. At the discretion of the Appointing Authority, the reduction-in-force implementation plan may be posted concurrently with the reduction-in-force notice. The reduction-in-force implementation plan shall:

- (1) Specify the position or positions to be abolished within specified units, divisions, facilities, agency-wide or any parts thereof, as determined by the Appointing Authority;
- (2) Provide for retention of affected employees based on type of appointment;
- (3) Require separation of probationary classified affected employees in affected job family levels, except those affected employees in probationary status after reinstatement from permanent classified status without a break in service, prior to the separation of any permanent classified affected employee in an affected job family level;
- (4) Provide for the retention of permanent classified affected employees in affected job family levels and those affected employees in probationary status after reinstatement, based on years of service;
- (5) Provide for exercise of displacement opportunities by permanent classified affected employees and those affected employees in probationary status after reinstatement if any displacement opportunities exist; and

(6) Provide for outplacement assistance and employment counseling from the Oklahoma Employment Security Commission and any other outplacement assistance and employment counseling that may be available. [74:840-2.27C(B)]

(d) Review of fiscal components. The Director of the Office of State Finance shall, within 5 business days of receipt, review the fiscal components of the reduction-in-force implementation plan and reject any plan that does not meet the requirements of Section 840-2.27C(D) of Title 74 of the Oklahoma Statutes.

530:10-13-12. Severance benefits

(a) Agencies shall provide mandatory severance benefits and may provide optional severance benefits in accordance with the provisions of Section 840-2.27D of Title 74 of the Oklahoma Statutes to eligible classified employees, eligible classified employees on probationary status after reinstatement from permanent classified status without a break in service, and regular unclassified employees who are separated as a result of the same reasons that a reduction-in-force is conducted for classified employees. Employees who are eligible for Priority Reemployment Consideration in accordance with Section 840-2.27C of Title 74 of the Oklahoma Statutes and Part 7 of this Subchapter who are employed by any agency before the scheduled date of reduction-in-force separations, are not eligible for severance benefits. Employees who are reemployed by the agency from which separated by a reduction-in-force less than 1 year after receiving severance benefits are required to repay such benefits in accordance with Section 840-2.27E of Title 74 of the Oklahoma Statutes.

(b) An agency which is separating only unclassified employees with 1 year or more continuous service for budgetary reasons may provide severance benefits pursuant to Sections 840-2.27D and 840-5.1A of Title 74 of the Oklahoma Statutes.

(c) An eligible employee who accepts severance benefits shall be required to sign an agreement, in a form prescribed by the Administrator, acknowledging that the employee accepts the severance benefits provided by the Appointing Authority pursuant to the provisions of Section 840-2.27D of Title 74 of the Oklahoma Statutes. The form provides information to the affected employee concerning his or her rights and responsibilities under Section 840-2.27E of Title 74 of the Oklahoma Statutes. [74:840-2.27E]

PART 3. REDUCTION-IN-FORCE PLAN REQUIREMENTS

530:10-13-32. Order of employee removal

(a) Agency-wide, or within displacement limits, if established, retention of affected employees shall be based on job family level and type of appointment [74:840-2.27C]. Subject to eligible classified employees accepting displacement offers, unclassified employees in a job family level on limited term appointments shall be separated first, followed by employees on project indefinite appointments, followed by employees on probationary appointments with the agency, agencies shall

## **Emergency Adoptions**

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separate probationary classified employees in affected job family levels, except those affected employees on probationary status after reinstatement from permanent classified status without a break in service, prior to the separation or voluntary demotion of any permanent classified employee from the same job family level [74:840 2.27C].

(b) Retention of permanent classified employees in affected job family levels and within displacement limits, if any are established, shall be based on years of service [74:840-2.27C].

(c) The Appointing Authority shall calculate retention points for all eligible classified employees, including those on an approved leave of absence. Eligible classified employees with more retention points shall be ranked higher; with the order of removal from a job family level in inverse order of that ranking. If tie scores occur, the ranking of employees who

have the same total retention points shall be determined first by giving a veteran's preference over affected nonveterans who have equal retention points to the affected veteran and then by giving preference for retention according to years of service in the agency. If a tie continues to exist, retention status shall be determined by a method established by the Appointing Authority and described in the reduction-in-force implementation plan [74:840-2.27C].

(d) For purposes of a reduction-in-force, any permanent classified employee on a detail to special duty shall be ranked on the basis of base job family level, not on the basis of the job to which detailed.

*[OAR Docket #10-1240; filed 10-26-10]*

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# 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

1:2010-45.

### EXECUTIVE ORDER 2010-45

I, Brad Henry, Governor of the State of Oklahoma, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. to 5:00 p.m. on Monday, October 18, 2010, to honor Justice Marian P. Opala, who died on Monday, October 11, 2010, at age 89.

Justice Opala was born in Lodz, Poland, in 1921 and served with distinction in defense of his native country in World War II. He became a citizen of the United States in 1953, the same year he graduated from Oklahoma City University School of Law. He started his legal career as an assistant county attorney in Oklahoma County and in 1956 he entered private practice. From 1960 to 1965, Justice Opala served as a Supreme Court referee and then served as a staff attorney for Justice Rooney McInerney. In 1969, he served as the first administrator of the state's court system until 1977. He then served as a judge on the State Industrial Court, now know as the Oklahoma Workers' Compensation Court, from 1977 to 1978.

In 1978, Governor David Boren appointed Justice Opala to the Supreme Court of Oklahoma, where he served until his death. He served as the court's Chief Justice from January 1, 1991, to December 31, 1992. In addition to his duties on the court, Justice Opala was an adjunct professor of law at

the University of Oklahoma, Oklahoma City University, and University of Tulsa. Justice Opala was a member of the Order of the Coif and the American Law Institute. In 1993, he was appointed as a public member of the Administrative Conference of the United States.

Justice Opala made great contributions to the State of Oklahoma and dedicated his life to public service. The First Lady and I join all Oklahomans in mourning his passing.

This executive order shall be forwarded to the Director of Central Services who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 14 day of October, 2010.

BY THE GOVERNOR OF THE  
STATE OF OKLAHOMA

Brad Henry

ATTEST:  
M. Susan Savage  
Secretary of State

[OAR Docket #10-1232; filed 10-25-10]

