Rules Agenda
April 10, 2008

I. Items subject to the Administrative Procedures Act (Emergency)

Page 2 A. Revising DDSD rules to provide current Home and Community Based Services Waiver provisions for respite care, including types of respite care. Other revisions denote a new level of support, pervasive level of support, through agency companion services and agency companion services salary options. **(Reference APA WF # 08-03)**

Page 13 B. Revising rules to include the Oklahoma Municipal Assurance Group as an approved carrier within the Insure Oklahoma/O-EPIC carrier definition. **(Reference APA WF # 08-09)**

I. Items subject to the Administrative Procedures Act (Emergency)

A. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 55. Respite Care
OAC 317:30-5-515. through 30-5-519.[AMENDED]
Chapter 40. Developmental Disabilities Services
Subchapter 5. ~~Client~~ Member Services
Part 1. Agency Companion/Adult Companion ~~Foster Care~~ Services ~~by Agency~~
OAC 317:40-5-3. [AMENDED]
OAC 317:40-5-9. [AMENDED]
(Reference APA WF # 08-03 A & B)

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 facilitate consistency with the Home and Community-Based Services Waivers, approved by the Centers for Medicare and Medicaid Services (CMS) effective July 1, 2007, and Medicaid provider requirements. The proposed rules provide additional service options for persons with mental retardation and certain persons with related conditions to receive necessary services and supports.

SUMMARY: Rules for the Developmental Disabilities Services Division (DDSD) Home and Community-Based Services (HCBS) Waivers are revised to provide current provisions for respite care for persons with mental retardation and certain persons with related conditions. Respite care options and limits are clarified; specifically, DDSD SoonerCare members will not be eligible for respite care when in OKDHS custody and out-of-home placement funded by OKDHS Children and Family Services Division. Agency companion service rules are amended to add another level of support for individuals who require additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. Other revisions delineate agency companion services salary options, which include the contractor and employer models, and use of specific OKDHS forms.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency as well as the Oklahoma Department of Human Services.

RULE LENGTH IMPACT: These revisions will have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 27, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: June 1, 2008, or immediately upon Governor's approval, whichever is later.

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising DDSD rules to provide current Home and Community Based Services Waiver provisions for respite care, including types of respite care. Other revisions denote a new level of support, pervasive level of support, through agency companion services and agency companion services salary options.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 55. RESPITE CARE

317:30-5-515. ~~Introduction to waiver services and eligible providers~~ Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

~~(a) **Introduction to waiver services.**~~ The Oklahoma Health Care Authority administers ~~two home and community based waivers for services to individuals with~~ Home and Community-Based Services (HCBS) Waivers for persons with mental retardation or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. ~~Both waivers are enacted under Section 1915(c) of the Social Security Act.~~ Each waiver allows payment for ~~services provided to eligible individuals that are not covered through Oklahoma's Medicaid program~~ respite care as defined in the waiver approved by the Centers for Medicare and Medicaid Services. ~~Waiver services, when utilized with services normally covered by Medicaid, provide for health and developmental needs of individuals who otherwise would not be able to live in a home or community setting. The first waiver, implemented in 1988, provides home and community based services for mentally retarded individuals who otherwise require the level of care in an Intermediate Care Facility for the Mentally Retarded. The second waiver, implemented in 1991,~~

~~provides home and community based services to persons with mental retardation or related conditions who are inappropriately placed in nursing facilities. The specific services provided are the same in each waiver and may only be provided to Medicaid-eligible individuals outside of a nursing facility. Any waiver service should be appropriate to the client's needs and must be written on the client's Individual Habilitation Plan (IHP). The IHP is developed annually by an interdisciplinary team (IDT). The IHP contains detailed descriptions of services provided, documentation of frequency of services and types of providers to provide services.~~

~~(b) **Eligible providers**. All Respite Care providers must have entered into contractual agreements (MA-S-342) with the Oklahoma Health Care Authority to supply Home and Community Based Waiver Services for the Mentally Retarded.~~

317:30-5-516. Coverage

All ~~Respite Care Services will~~ respite care must be included in the ~~IHP and reflected in the approved plan of care~~ member's Individual Plan (IP). Arrangements for ~~care under~~ this ~~program will~~ service must be made through the ~~individual client's~~ member's case manager.

317:30-5-517. Description of services

~~(a)~~ Respite care ~~services outside the beneficiary's home include the following~~ is:

(1) ~~**Minimum qualifications**. Respite care providers must complete in-service training which includes 21 hours of NOVA training and the Department of Human Services/-Developmental Disabilities Services Division (DHS/DDSD) sanctioned training curriculum in accordance with the scheduled authorized by DDSD, have the ability to implement goals and objectives on the Individual Habilitation Plan and be emotionally and financially stable, in good health, and of reputable character.~~ available to eligible members not receiving daily living supports or group home services and who are unable to care for themselves; and

(2) ~~**Description of services**. Temporary supervision and assistance provided to an eligible individual six years of age and older who is residing with a natural, adoptive or foster family. Services are intended to allow the primary care provider (natural or foster family) relief and thereby strengthen the primary care provider's capacity to supply optimum support and assistance to the individual. Services are supplied in 24 hour increments. Three levels of respite care, based upon the service recipient's level of need as determined by the Interdisciplinary Team, are recognized:~~ furnished on a short-term basis due to the absence or need for relief of those

persons normally providing the care, and includes:

(A) ~~Maximum supervision for those individuals with extensive needs~~ homemaker respite per OAC 317:30-5-535 through 317:30-5-538;

(B) ~~Close supervision for those individuals with moderate needs; and~~ daily respite provided in a group home.

(i) Group homes providing respite must be licensed per OAC 340:100-6.

(ii) Respite care provided in a group home is authorized as respite at the applicable group home rate as identified in the member's Plan of Care;

(C) ~~Intermittent supervision for those individuals with minimum needs~~ daily respite provided in an agency companion services (ACS) home.

(i) Respite must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340:100-3-38.

(ii) Respite provided in an ACS home is authorized as respite at the applicable level of support per OAC 317:40-5-3.

(iii) Respite providers are limited to providing 52 days of respite per year when they concurrently provide ACS; and

(D) daily respite provided in any other approved home. Respite:

(i) must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340-100-3-38;

(ii) is based on the member's needs and includes:

(I) maximum supervision - for members with extensive needs;

(II) close supervision - for members with moderate needs; and

(III) intermittent supervision - for members with minimum needs; and

(iii) providers must:

(I) pass a background investigation per OAC 317:40-5-40 and OAC 340:100-3-39; and

(II) be at least 18 years of age.

~~(b) Respite care services in beneficiary's home include the following:~~

~~(1) **Minimum qualifications.** In-beneficiary home respite care providers must have completed the Department of Human Services/Developmental Services Division (DDSD/DHS) sanctioned training curriculum in accordance with schedule authorized by DDSD. In addition, the provider must be emotionally stable; in good health; and have reputable character.~~

~~(2) **Description of services**. Temporary supervision and~~

~~assistance provided to an eligible individual six years of age and older who is residing with a natural, adoptive or foster family. Services are intended to allow the primary care provider (natural or foster family) relief and thereby strengthen the primary care provider's capacity to supply optimum support and assistance to the individual. Services are supplied in 24 hour increments. Three levels of respite care, based upon the service recipient's level of need as determined by the Interdisciplinary Team, are recognized:~~

~~(A) Maximum supervision for those individuals with extensive needs;~~

~~(B) Close supervision for those individuals with moderate needs; and~~

~~(C) Intermittent supervision for those individuals with minimum needs.~~

317:30-5-518. Coverage limitations

(a) Payment ~~will~~ is not ~~be~~ made for ~~Specialized Foster Care Services~~ daily respite care and ~~Respite Care Services~~ specialized foster care or agency companion services for the same ~~client~~ member on the same date of service.

(b) ~~Coverage limitations for respite~~ Respite care ~~services are as follows~~:

(1) ~~Outside beneficiary's home:~~ is not available to members in the custody of the Oklahoma Department of Human Services (OKDHS) and in out-of-home placement funded by the OKDHS Children and Family Services Division; and

~~(A) Intermittent Supervision: daily rate limited to 90 days each 12 months.~~

~~(B) Close Supervision: daily rate limited to 90 days each 12 months.~~

~~(C) Maximum Supervision: daily rate limited to 90 days each 12 months.~~

(2) ~~In beneficiary's home:~~ for members not receiving ACS, is limited to 30 days or 720 hours annually per member, except as approved by the Developmental Disabilities Services Division director and authorized in the member's Plan of Care; or

~~(A) Intermittent Supervision: daily rate limited to 90 days each 12 months.~~

~~(B) Close Supervision: daily rate limited to 90 days each 12 months.~~

~~(C) Maximum Supervision: daily rate limited to 90 days each 12 months.~~

(3) for members receiving ACS, is limited in accordance with OAC 317:40-5-8.

317:30-5-519. Diagnosis code

The ICD-9-CM diagnosis code for ~~Respite Care~~ respite care is 319

(~~Mental Retardation~~ mental retardation). This code must be entered in ~~Item~~ field 21 on ~~the HCFA-1500~~ Form CMS-1500.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 5. ~~CLIENT~~ MEMBER SERVICES
PART 1. AGENCY COMPANION/ADULT COMPANION ~~FOSTER CARE~~ SERVICES ~~BY AGENCY~~

317:40-5-3. Scope of agency companion services

(a) Agency companion services (ACS):
   (1) are provided by private agencies contracted with the Oklahoma Health Care Authority (OHCA);
   (2) are available to members who are eligible for services through the Community Waiver or Homeward Bound Waiver;
   (3) are based on the member's need for support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58;
   (4) are provided in a nurturing environment in the member's home, the companion's home, or in a mutually rented or owned home; and
   (5) support visitation desired by the member with his or her natural family and friends, and in accordance with the member's IP.

(b) An agency companion:
   (1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD);
   (2) is limited to serving as companion for one member~~;~~ . ~~exceptions~~ Exceptions may be granted only upon review and approval by the DDSD director or designee;
   (3) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC ~~317:40-5-5~~ 317:40-5.
      (A) Employment as an agency companion is the companion's primary employment.
      (B) The companion may have other employment when:
         (i) serving members approved for intermittent or regular levels of support;
         (ii) the Personal Support Team addresses all documented related concerns in the member's IP; and
         (iii) the other employment is approved in advance by the DDSD area manager or designee; and
   (4) approved for other employment may not be employed in another position that ~~required~~ requires on-call duties.
      (A) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed by

the member, the companion must terminate, within 30 days:

(i) the other employment; or

(ii) his or her employment as an agency companion.

(B) Homemaker, habilitation training specialist, and respite services are not provided in order for the companion to perform other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.

(1) Therapeutic leave:

(A) is a Medicaid payment made to the contract provider to enable the member to retain services; and

(B) is claimed when:

(i) the member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless whether the companion is present; or

(ii) the companion uses authorized ~~relief~~ respite time;

(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year; and

(D) cannot be accrued from one Plan of Care year to the next~~;~~ .

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate.

(3) The provider agency pays the agency companion the salary that he or she ~~earns when~~ would earn if the member ~~is~~ were not on therapeutic leave.

(d) Levels of support for the member and corresponding payment are:

(1) determined by authorized DDSD staff in accordance with levels described in (A) through (~~C~~ D); and

(2) re-evaluated when the member has a change in agency companion providers.

(A) **Intermittent level of support**. Intermittent level of support is authorized when the member:

(i) requires minimal assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) communicates needs and wants;

(iii) is able to spend short periods of time unsupervised inside and outside the home;

(iv) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments or other activities, and arranging transportation; and

(v) has stable or no ongoing medical or behavioral difficulties.

(B) **Regular level of support**. Regular level of support is

authorized when the member:

(i) requires regular, frequent and sometimes constant assistance and support or is totally dependent on others to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) has difficulty or is unable to communicate basic needs and wants;

(iii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments or other activities, and arranging transportation; and

(iv) requires regular monitoring and assistance with health, medication, or behavior interventions, and may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support**. Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:

(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments or other activities, and arranging transportation;

(ii) demonstrates ongoing complex medical or behavioral issues requiring specialized training courses per OAC 340:100-3-38.3; and

(iii) has medical support needs that are rated at Level 4, 5, or 6 on the Physical Status Review (PSR), per OAC 340:100-5-26. In cases where complex medical needs are not adequately characterized by the PSR, exceptions may be granted only upon review by the DDSD director or designee; or

(iv) requires a ~~Protective Intervention Plan~~ protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must be:

(I) approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14; and

(II) reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work

(MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system.

The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

317:40-5-8. ~~Development of the~~ Agency ~~Companion Services Service Authorization Budget~~ companion services service authorization budget

Upon approval of the home profile ~~as described in~~ per OAC 317:40-5-40, the companion, ~~the~~ provider agency, the Oklahoma Department of Human ~~Services'~~ Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, ~~Agency Companion Services~~ agency companion services (ACS) staff, and others as appropriate meet to develop a ~~Service Authorization Budget (SAB),~~ service authorization budget. OKDHS ~~form DDS-SAB-1. The SAB~~ Form 06AC074E, Service Authorization Budget, is used to develop the individual service budget for the ~~service recipient's~~ member's program and is updated annually by the ~~service recipient's~~ member's Personal Support Team (Team).

(1) The companion receives:

(A) a salary based on the level of support needed by the ~~service recipient~~ member. The level of support is determined by authorized DDSD staff ~~as defined in the criteria for support (~~ per OAC 317:40-5-3~~)~~. ~~(2)~~ The ACS rate for the:

(i) employer model includes funding for the provider agency for the provision of benefits to the companion~~.~~ ; and

(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion; and

~~(3)~~ (B) ~~The companion receives 660 units per year of~~ any combination of ~~Habilitation Training Specialist, Homemaker, Respite, and Homemaker Respite Services~~ hourly or daily respite per Plan of Care year to equal 660 hours in order to provide ~~relief time~~ respite to the companion as reflected on ~~the SAB beginning from the date the service recipient and the companion begin living together~~ Form 06AC074E.

~~(A)~~ (i) ~~Additional relief time~~ Habilitation training specialist (HTS) services may be approved by the DDSD director or designee if providing ACS with additional ~~relief~~ support represents the most cost-effective

placement for the ~~service recipient~~ member and the member has an ongoing pattern of not:

~~(i)~~ (I) ~~the service recipient has an on-going pattern of not~~ sleeping at night; or

~~(ii)~~ (II) ~~the service recipient has an on-going pattern of not~~ working or attending employment services, in spite of continuing efforts by the Team.

~~(B)~~ (ii) ~~The additional relief time given~~ HTS units authorized must be reduced when the on-going situation changes.

~~(C)~~ (iii) ~~Additional relief time given~~ HTS authorizations must be reviewed annually or more often if needed.

~~(4)~~ (2) ~~The~~ OKDHS Form ~~DDS-SAB-1~~ 6AC074E reflects the amount of room and board the ~~service recipient~~ member pays to the companion. If the amount exceeds ~~$400~~ $450, the increase must be:

(A) agreed to by the ~~service recipient~~ member and, if applicable, legal guardian~~, if any~~;

(B) recommended by the ~~personal support team (~~Team~~)~~; and

(C) submitted with written justification attached to ~~the DDS-SAB-1~~ OKDHS Form 06AC074E to the DDSD area manager or designee for approval.

~~(5)~~ (3) Prior to the ~~SAB~~ meeting to discuss the service authorization budget, a back-up ~~support~~ plan identifying ~~relief~~ respite staff is developed by the provider agency program coordination staff and ~~the~~ companion.

(A) The back-up plan:

(i) is submitted to the DDSD case manager for approval~~,~~ and attached to ~~the~~ completed OKDHS Form ~~DDS-SAB-1.~~ 06AC074E;

~~(B)~~ (ii) ~~The back-up plan~~ describes expected and emergency back-up support and program monitoring for the home~~.~~ ; and

~~(C)~~ (iii) ~~The plan~~ is signed by the companion, ~~the~~ provider agency representative, and ~~the~~ DDSD case manager.

~~(D)~~ (B) The companion and ~~the~~ provider agency program coordination staff equally share the responsibility to ~~work together in identifying~~ identify approved ~~relief staff~~ respite providers who are:

(i) ~~are~~ knowledgeable ~~of~~ about the ~~service recipient~~ member;

(ii) trained to implement the ~~service recipient's~~ member's Individual Plan (Plan);

(iii) ~~have completed training required by~~ trained per OAC 340:100-3-38; and

(iv) ~~are~~ involved in the ~~service recipient's~~ member's daily life.

~~(E)~~ (C) The spouse or other adult residing in the home may provide ~~companion services~~ ACS in the absence of the

companion, if trained in accordance with OAC 340:100-3-38. The spouse or other adult residing in the home cannot:

(i) serve as paid ~~relief~~ respite staff; and

(ii) ~~cannot~~ be paid simultaneously with the companion.

~~(F)~~ (D) The companion and ~~relief~~ respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. ~~The activities~~ Activities selected ~~are to~~ must be affordable to the ~~service recipient~~ member and ~~the relief~~ respite staff. Concerns about affordability are ~~brought~~ presented to the Team for resolution.

~~(G) The companion plans relief time and gives sufficient notice to the provider agency so that the companion and the provider agency have relief staff available.~~

~~(6)~~ (4) The ~~service recipient~~ member is allowed therapeutic leave in accordance with OAC 317:40-5-3.

B. **CHAPTER 45. INSURE OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**
Subchapter 1. General Provisions
OAC 317:45-1-3. [AMENDED]
(Reference APA WF # 08-09)

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 the Oklahoma Municipal Assurance Group (OMAG) as an approved carrier for Insure Oklahoma/O-EPIC. Since OMAG is not presently an approved carrier, an adverse action could potentially occur where healthy members or groups currently under OMAG begin to switch to approved carriers in order to aid in subsidizing health care premiums for qualified individuals. Revisions are needed to prevent this member migration from occurring and help ensure stabilization among the carrier groups.

SUMMARY: Agency rules are revised to include the Oklahoma Municipal Assurance Group (OMAG) as an approved carrier in the Insure Oklahoma/O-EPIC carrier definition. Because of the different authority under which OMAG operates, the group has not been included as an approved carrier for Insure Oklahoma/O-EPIC purposes. The OMAG is similar in operation to the Multiple Employer Welfare Arrangement (MEWA) which is presently defined in Insure Oklahoma/O-EPIC policy as an approved carrier. Because OMAG is not currently an approved carrier, an adverse action could potentially occur where healthy members or groups currently under OMAG begin to switch to approved carriers in order to aid in subsidizing health care premiums for qualified individuals. By including OMAG as an approved carrier, excessive member migration will be prevented from occurring thereby helping to ensure stabilization among the carrier groups.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency.

RULE LENGTH IMPACT: These revisions will have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 27, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: June 1, 2008 or immediately upon

Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 1225 of the 1st Session of the 51st Oklahoma Legislature; Section 1001 et seq. of Title 74 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to include the Oklahoma Municipal Assurance Group as an approved carrier within the Insure Oklahoma/ O-EPIC carrier definition.

CHAPTER 45. INSURE OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) an insurance company, ~~group health service or Health Maintenance Organization (HMO) that provides health benefits pursuant to Title 36 O.S., Section 6512~~ insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) ~~A~~ a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department; ~~or~~

(C) ~~A~~ a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36~~.~~; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for

and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"Dependent" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 23 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a ~~Carrier~~ carrier that indicates services rendered and financial responsibilities for the ~~Carrier~~ carrier and Insure Oklahoma/O-EPIC ~~PA~~ member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Individual Plan" means the ~~O-EPIC program that provides services to those individuals who do not meet the criteria for O-EPIC PA~~ safety net program for those qualified individuals who do not have access to Insure Oklahoma/O-EPIC ESI.

"Insure Oklahoma/O-EPIC" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"PCP" means Primary Care Provider.

~~**"Insure Oklahoma/O-EPIC"** means the Oklahoma Employer and Employee Partnership for Insurance Coverage program.~~

"Insure Oklahoma/O-EPIC IP" means the Individual Plan program.

"Insure Oklahoma/O-EPIC ~~PA~~ ESI" means the ~~Premium Assistance~~ Employer Sponsored Insurance program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

~~**"Oklahoma Employer and Employee Partnership for Insurance Coverage"** means a health plan purchasing strategy in which a state uses public funds to pay for a portion of the costs of health plan~~

~~coverage for eligible populations.~~

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

~~**"Premium Assistance"** means the O-EPIC program that provides premium assistance to small business for certain employees.~~

"Primary Care Provider" means a provider under contract to the Oklahoma Health Care Authority to provide primary care services, including all medically-necessary referrals.

~~**"Primary Employer"** means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.~~

"Premium" means a monthly payment to a ~~Carrier~~ carrier for health plan coverage.

"QHP" means Qualified Health Plan.

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma/O-EPIC program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying ~~Events~~ events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority or its designee.

"TPA" means the Third Party Administrator.

"Third Party Administrator" means the entity contracted by the State to provide the administration of the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage program.