PUBLIC HEARING FOR THE CONSIDERATION OF PERMANENT RULEMAKING UNDER THE OKLAHOMA AMINISTRATIVE PROCEDURES ACT

PLACE OF HEARING: BUSINESS OFFICE OF THE OKLAHOMA HEALTH CARE AUTHORITY (Charles Ed McFall Board Room)
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

TIME OF HEARING: 1:00 PM

DATE OF HEARING: January 19, 2021

AGENDA FOR THE MEETING

1. INTRODUCTIONS AND PURPOSE OF MEETING

2. RULES TO BE CONSIDERED

A. **APA WF # 20-01 High-Investment Drugs Carve-Out —** ADDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-5-42.20 and 317:30-5-47.6*** and AMENDING ***OAC 317:30-3-31, 317:30-5-42.1, and 317:30-5-47*** to allow certain high-investment drugs to be reimbursed outside of the inpatient and outpatient hospital payment methodologies. Additionally, the proposed rule changes will require inpatient and outpatient hospitals to seek prior authorization of high-investment drugs and follow applicable requirements and conditions of payment. Lastly, revisions will align policy with current practice and correct grammatical errors.

B. **APA WF # 20-02 Retroactive Eligibility —** AMENDING agency rules at ***OAC 317:35-6-60*** and ADDING agency rules at ***OAC 317:35-6-60.2*** to allow for a retroactive period of eligibility for pregnant women and children. Revisions provide that, in addition to certifying an applicant for coverage from the date of certification forward, the applicant may also be certified for coverage for a retroactive period of three months directly prior to the date of application. Revisions will also specify the requirements that must be met to be eligible for retroactive coverage. The timely filing deadline in OAC 317:30-3-11 will still apply to the filing of any claims.

C. **APA WF # 20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility —** AMENDING agency rules at ***OAC 317:35-6-51*** and ADDING agency rules at ***OAC 317:35-6-55*** to bring the agency into compliance with the Advancing Chronic Care, Extenders and Social Services Act, referred to as the ACCESS Act and included in

Public Law No. 115-123 § 53103. The ACCESS Act changed the way qualified lottery winnings or qualified gambling winnings of $80,000 and above, which are paid out in a single payout option, are treated when determining MAGI-based income eligibility. Previous federal regulations and OHCA rules required that all lump sum income, including lottery and gambling winnings, be counted as income only in the month received. Winnings will still be counted as income against the SoonerCare household in the month received; however, winnings of $80,000 and above which are paid out in a single payout option will be counted in multiple months and in equal monthly installments against the individual household member receiving the winnings. Lottery winnings that are paid out in installments over a period of time will be treated as recurring income. The formula for counting winnings of $80,000 and above is set forth in the new OHCA policy at OAC 317:35-6-55(b) and (c).

D. **APA WF # 20-05 Continuation of Services Pending Appeals —** ADDING agency rules at ***OAC 317:2-1-2.6*** to comply with Section 431.230 of Title 42 of the Code of Federal Regulations by describing the conditions in which Medicaid benefits will continue or be reinstated pending an appeal. Additionally, the proposed new rule will describe the application, obligations, and implications for the appellant when Medicaid benefits are continued or reinstated pending an appeal.

E-1. **APA WF # 20-06B Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:35-18-6*** to comply with the home health final rule in which the DME and supplies benefit was revised from an optional benefit to a mandatory benefit and was made subject to the scope of the home health benefit. This change is being made to mirror language in federal regulation.

E-2. **APA WF # 20-06D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:50-1-14*** to comply with the home health final rule in which the DME and supplies benefit was revised from an optional benefit to a mandatory benefit and was made subject to the scope of the home health benefit. This change is being made to mirror language in federal regulation.

F. **APA WF # 20-11 Medicare Part C (Medicare Advantage) —** AMENDING agency rules at ***OAC 317:30-3-25*** to standardize the language in policy regarding the payment of Medicare deductibles, coinsurance, and copays between Medicare Part A, Part B, and Part C.

G. **APA WF # 20-22 Programs of All Inclusive-Care for the Elderly**

(PACE) — AMENDING agency rules at ***OAC 317:35-18-5 and 317:35-18-7*** to update policy regarding enrollment denials for participation in PACE to reflect current business practices. Additional policy changes will add language to clarify and establish OHCA's role in reviewing justifications for expedited appeals from PACE organizations. All proposed rule changes will align policy with Section 460.122 of Title 42 of the Code of the Federal Regulations.

H. **APA WF # 20-23 Developmental Disabilities Services (DDS) Revisions** — AMENDING agency rules at ***OAC 317:40-1-1, 317:40-5-3, 317:40-5-5, 317:40-5-40, 317:40-5-100, 317:40-5-152, and 317:40-7-11*** and ADDING agency rules at ***OAC 317:40-1-4*** to change the timeframe from ninety (90) days to one (1) calendar year for which a required physical health examination and medical evaluation can be completed when an individual is applying for the DDS Home and Community-Based Services (HCBS) waiver. These revisions improve the process of certifying cases for HCBS waivers by making it more efficient. DDS may also require a current medical evaluation when a significant change of condition, disability, or physical health status is noted. Additionally, revisions will add language defining remote services that can be provided in the member's home, family home, or employment site. Remote services are created to promote the independence of a member who receives DDS services through remote services. Revisions will also address the new agency companion household criteria and new agency champion provider requirements, as well as, modify the procedures for the DDS home profile process. Agency companion providers may not simultaneously serve more than three members through any combination of companion or respite services. Further, revisions will establish new criteria on how the member is to obtain assistive technology devices and clarify instructions to staff whom are providing Stabilization Services authorized through remote supports. The requirement to add Assistive Technology devices must be prescribed by a physician with a SoonerCare contract. The proposed revisions increase the designated amount than an area resource development staff can approve or deny for AT from $2500 up to $5000. Finally, revisions will also increase the amount the state office AT programs manager can approve for AT from $2500 to $5000 or more.

I. **APA WF # 20-29 Provider Refund to Member when Copayment is Over-Collected** — AMENDING agency rules at ***OAC 317:30-3-5*** will describe the provider's requirement to refund any amount the provider collected from the member for copayment in error and/or collected after the family had reached its aggregate cost sharing maximum.

J. **APA WF # 20-33 Bariatric Surgery Revisions** — AMENDING agency rules at ***OAC 317:30-5-137 and 317:30-5-140*** and REVOKING agency rules at ***OAC 317:30-5-137.1, 317:30-5-137.2***

and 317:30-5-141 to update bariatric surgery requirements and guidelines to reflect current business practice. Additional revisions will correct grammatical and/or formatting errors, as well as, revoking obsolete sections.

A.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION
317:30-3-31 [AMENDED]
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS
317:30-5-42.1 [AMENDED]
317:30-5-42.20 [NEW]
317:30-5-47 [AMENDED]
317:30-5-47.6 [NEW]
(REFERENCE APA WF # 20-01)

317:30-3-31. Prior authorization for health care-related goods and services

(a) Under the ~~Oklahoma~~ SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

(1) ~~the~~The relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and/or

(2) ~~any~~Any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination, either through the provider portal, or for requests made for out-of-state services, meals, mileage, transportation and lodging, by letter or other written communication. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

(1) Physical therapy for children;
(2) Speech therapy for children;
(3) Occupational therapy for children;
(4) High Tech Imaging (for ex. CT, MRA, MRI, PET);
(5) Some dental procedures, including, but not limited to

orthodontics (orthodontics are covered for children only);
(6) Inpatient psychiatric services;
(7) Some prescription drugs ~~and/or~~ , physician administered, and/or high-investment drugs;
(8) Ventilators;
(9) Hearing aids (covered for children only);
(10) Prosthetics;
(11) High risk ~~OB~~obstetrical (OB) services;
(12) Drug testing;
(13) Enteral therapy (covered for children only);
(14) Hyperalimentation;
(15) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in ~~Oklahoma's~~the Oklahoma Medicaid State Plan;
(16) Adaptive equipment for persons residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
(17) Some ancillary services provided in a ~~long term~~long-term care hospital or in a long term care facility;
(18) Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts;
(19) Allergy testing and immunotherapy;
(20) Bariatric surgery;
(21) Genetic testing;
(22) Out-of-state services; and
(23) Meals, travel, and lodging.

(d) ~~Providers should refer to the relevant Part of OAC 317:30-5 for additional, provider-specific guidance on PA requirements. Providers may also refer to the OHCA Provider Billing and Procedure Manual, available on OHCA's website, and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual to see how and/or where to submit PA requests, as well as to find information about documentation.~~Providers should refer to the provider-specific Part for PA requirements. For additional PA information and submission requests, providers may refer to the OHCA Provider Billing and Procedure Manual and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual available at https://okhca.org.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to the Oklahoma Health Care Authority (OHCA) contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.
(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.
(1) The care is directed by a physician or dentist.
(2) The care is medically necessary.
(3) The member is not an inpatient [refer to Oklahoma Administrative Code (OAC) 317:30-5-41].
(4) The service is provided in an approved hospital facility.
(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).
(d) In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.
(e) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.
(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital-based setting. Coverage is limited to one (1) evaluation/re-evaluation visit (unit) per discipline per calendar year and fifteen (15) visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).
(g) Diabetes self-management ~~training (DSMT)~~education and support (DSMES) services ~~is~~are provided to members diagnosed with diabetes. ~~DSMT~~DSMES services are comprised of one (1) hour of individual instruction (face-to-face encounters between the ~~certified~~ diabetes educator and the member) and nine (9) hours of group instruction on diabetes self-management. Members shall receive up to ten (10) hours of services during the first twelve (12) month period beginning with the initial training date. After the first twelve (12) month period has ended, members shall only be eligible for two (2) hours of individual instruction on ~~DSMT~~DSMES per calendar year. Refer to OAC 317:30-5-1080 through 317:30-5-1084 for specific provider and program requirements, and reimbursement methodology.
(h) For high-investment drugs, refer to OAC 317:30-5-42.20.

317:30-5-42.20. High-investment drugs – outpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an outpatient hospital.
(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at

https://okhca.org. This list may be updated as deemed necessary.
(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the outpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].
(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state outpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state outpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) ~~laboratory~~Laboratory services;

(B) ~~prosthetic~~Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) ~~technical~~Technical component on radiology services;

(D) ~~transportation~~Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) ~~pre-admission~~Pre-admission diagnostic testing performed within ~~72~~seventy-two (72) hours of admission; and

(F) ~~organ~~Organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the ~~Oklahoma~~ SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(5) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not

made for inappropriate transfers.
(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.
(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.
(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed ~~100%~~one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
(10) All inpatient services are reimbursed per the methodology described in this ~~section~~Section and/or as approved under the Oklahoma ~~State~~ Medicaid State Plan.
(11) For high-investment drugs, refer to OAC 317:30-5-47.6

317:30-5-47.6. High-investment drugs - inpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital.
(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at https://okhca.org. This list may be updated as deemed necessary.
(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the inpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].
(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state inpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

B.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60 [AMENDED]

317:35-6-60.2 [NEW]

(REFERENCE APA WF # 20-02)

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

~~An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the date of certification. The period of certification may not be for a retroactive period unless otherwise prior approved by OHCA. The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.~~

(a) **General rules of certification.**

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three (3) month period directly prior to the date of application. This only applies if the individual received covered medical services at any time during that period, and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

~~(1)~~(b) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

~~(2)~~(c) **Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.** The certification period for the individual related to the children or parent and caretaker relative groups is ~~12~~twelve (12) months. The

certification period can be less than ~~12~~twelve (12) months if the individual:

~~(A)~~(1) ~~is~~Is certified as eligible in a money payment case during the ~~12-month~~twelve-month (12-month) period;

~~(B)~~(2) ~~is~~Is certified for long-term care during the ~~12-month~~twelve-month (12-month) period;

~~(C)~~(3) ~~becomes~~Becomes ineligible for SoonerCare after the initial month; or

~~(D)~~(4) ~~becomes~~Becomes financially ineligible.

~~(i)~~(A) If an income change after certification causes the case to exceed the income standard, the case is closed.

~~(ii)~~(B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy-related services through the postpartum period.

~~(3)~~(d) **Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two (2) months following the month the pregnancy ends. Financial ~~eligibilityis~~eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

~~(4)~~(e) **Certification of newborn child deemed eligible.**

~~(A)~~(1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

~~(B)~~(2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. ~~No~~In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at ~~OKDHS~~DHS. The referral enables child support services to be

initiated.

~~(C)~~ (3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

~~(i)~~ (A) loses Oklahoma residence; or

~~(ii)~~ (B) expires.

~~(D)~~ (4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-60.2. Retroactive eligibility.

(a) Retroactive eligibility, as outlined in this section, shall be available to pregnant women and/or members under the age of nineteen (19). For retroactive eligibility rules related to other SoonerCare population groups, refer to Oklahoma Administrative Code (OAC) 317:35-7-60(b).

(b) In addition to the period of eligibility specified in Oklahoma Administrative Code (OAC) 317:35-6-60, an applicant, or individuals within the applicant's household, shall be eligible for SoonerCare benefits up to three (3) months prior to the date of application if all of the following requirements are met:

(1) The individual for whom retroactive coverage is being requested would have been eligible for SoonerCare coverage if an application for SoonerCare had been made during the retroactive month.

(A) The individual does not have to be eligible for the month of application to be found eligible for one (1) of the three (3) retroactive months.

(B) The eligibility factors (e.g. income, residency, household composition, etc.) are evaluated separately for each retroactive month for which retroactive eligibility is being requested.

(2) The applicant completes the retroactive eligibility application form and provides, within six (6) months of the date the services were provided, documentation for verification purposes as requested by SoonerCare.

(3) The individual applying for retroactive coverage states that the individual for whom retroactive coverage is being requested received reimbursable SoonerCare services which were provided by a SoonerCare-contracted provider during the retroactive month.

(4) An applicant cannot be approved for retroactive coverage for a month in which his or her application was previously denied.

(c) Per 42 Code of Federal Regulations (CFR) § 435.915(b), if an applicant is determined to be eligible for retroactive coverage at any time during the requested retroactive month, then coverage will begin on the first (1st) day of the month and be effective for the entire month.

(d) If the applicant is applying for SoonerCare benefits due to

pregnancy, then the applicant must have been pregnant during the requested retroactive month.
(e) Regardless of retroactive eligibility being granted, the requirement for the claim to be filed timely, per OAC 317:30-3-11, is still in effect.
(f) Retroactive coverage for SoonerCare health services received during a retroactive month will be secondary to any third-party which has primary responsibility for payment. If the individual eligible for retroactive coverage has already paid for the health services, the provider may refund the payment and bill SoonerCare in accordance with the timely filing requirements in OAC 317:30-3-11.
(g) Retroactive coverage for SoonerCare reimbursable health services that require prior authorization shall not be denied solely because of a failure to secure prior authorization. Medical necessity, however, must be established before reimbursement can be made.
(h) Denials of requests for retroactive eligibility may be appealed in accordance with OAC 317:2-1-2(d)(1)(F).

C.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 6. COUNTABLE INCOME FOR MAGI
317:35-6-51 [AMENDED]
317:35-6-55 [NEW]
(REFERENCE APA WF # 20-03)

317:35-6-51. Exceptions to Internal Revenue Code rules

(a) The following sources of income are excluded from household income for SoonerCare eligibility under ~~MAGI~~Modified Adjusted Gross Income (MAGI), regardless of whether they are included in MAGI in Section 36B of the Internal Revenue Code:

(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and

(2) The following types of American Indian / Alaska Native income:

(A) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(B) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(i) Rights of ownership or possession in any lands described in Paragraph (a)(2)(A) of this section; or

(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(C) Distributions resulting from real property ownership interests related to natural resources and improvements:

(i) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(ii) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(D) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(E) Student financial assistance provided under the Bureau of Indian Affairs education programs; and

(F) Distributions from Alaska Native Corporations and Settlement Trusts.

(b) Amounts received as a lump sum are counted as income only in the month received (see also ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-10-26), with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. If a lump sum amount is

received from an income source that is not counted in MAGI according to section 36B(d)(2)(B) of the Internal Revenue Code or the exceptions listed in this section, the amount is not counted.

317:35-6-55. Treatment of Qualified Lottery or Qualified Gambling Winnings

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

(1) "Qualified lottery winnings" means winnings from a sweepstakes, lottery, or pool described in paragraph three (3) of Section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association paid out in a single payout and not in installments over a period of time.

(2) "Qualified gambling winnings" means monetary winnings from gambling, as defined by Section (§) 1955(b)(4) of Title 18 of the United States Code (U.S.C.).

(3) "Undue hardship" means circumstances resulting from a loss or denial of SoonerCare eligibility that would deprive an individual of medical care, such that the individual's health or life would be endangered, or that would deprive the individual or his or her financially dependent family members of food, clothing, shelter, or other necessities of life.

(b) **Income determinations.** In accordance with 42 U.S.C. § 1396a(e)(14)(K), qualified lottery and gambling winnings shall be considered as income in determining the financial eligibility of individuals whose eligibility is determined based on the application of Modified Adjusted Gross Income (MAGI), as follows:

(1) Winnings less than $80,000 are counted in the month received;

(2) Winnings greater than or equal to $80,000, but less than $90,000, are counted as income over two (2) months, with an equal amount counted in each month;

(3) Winnings greater than or equal to $90,000, but less than $100,000, are counted as income over three (3) months, with an equal amount counted in each month;

(4) Winnings greater than or equal to $100,000 are counted as income over three (3) months, with one (1) additional month for every increment of $10,000 in winnings received over $100,000, with an equal amount counted in each month; and

(5) The maximum period of time over which winnings may be counted is one hundred and twenty (120) months, which would apply to winnings greater than or equal to $1,260,000.

(c) **Treatment of household members.** Qualified lottery and gambling winnings shall be counted as household income for all household members in the month of receipt; however, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individual receiving the winnings.

(d) **Undue hardship.** An individual who loses or is denied

eligibility due to qualified lottery or gambling winnings may timely file a member appeal, in accordance with Oklahoma Administrative Code 317:2-1-2. If, as part of that appeal, the individual proves by a preponderance of the evidence that loss or denial of eligibility would result in undue hardship, eligibility shall be restored or approved, provided all other conditions of eligibility have been met.

(e) **Notice.** SoonerCare members or applicants who are determined financially ineligible due to the counting of lottery or gambling winnings will receive a notice of the date on which the lottery or gambling winnings will no longer be counted for eligibility purposes. The notice will also inform the member or applicant of the undue hardship exemption and of their opportunity to enroll in a Qualified Health Plan on the Federally Facilitated Exchange.

D.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
317:2-1-2.6 [NEW]
(Reference APA WF # 20-05)

317:2-1-2.6. Continuation of benefits or services pending appeal

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an Appellant submits a written request for a hearing within ten (10) days of the notice of the adverse agency action, the Appellant may also request that existing benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, Appellant's withdrawal of the appeal, or an initial hearing decision adverse to the Appellant.

(b) If the Appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ten (10) days of the notice of the adverse agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;

(2) When a request for a prior authorization is denied for a prescription drug. However:

(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;

(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;

(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;

(4) When coverage for a prescription drug is denied because the enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or

(5) When a physician or other licensed health care practitioner has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the Appellant's favor, OHCA may seek to recover reimbursement of all services received pending the hearing decision.

E-1.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
317:35-18-6 [AMENDED]
(REFERENCE APA WF # 20-06B)

317:35-18-6. PACE program benefits

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

(1) All SoonerCare-covered services, as specified in the State's approved ~~SoonerCare plan.~~Medicaid State Plan;

(2) ~~Interdisciplinary assessment~~IDT and treatment planning~~.~~;

(3) Primary care, including physician and nursing services~~.~~;

(4) Social work services~~.~~;

(5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services~~.~~;

(6) Personal care and supportive services~~.~~;

(7) Nutritional counseling~~.~~;

(8) Recreational therapy~~.~~;

(9) Transportation~~.~~;

(10) Meals~~.~~;

(11) Medical specialty services including, but not limited to the following:

(A) Anesthesiology~~.~~;

(B) Audiology~~.~~;

(C) Cardiology~~.~~;

(D) Dentistry~~.~~;

(E) Dermatology~~.~~;

(F) Gastroenterology~~.~~;

(G) Gynecology~~.~~;

(H) Internal medicine~~.~~;

(I) Nephrology~~.~~;

(J) Neurosurgery~~.~~;

(K) Oncology~~.~~;

(L) Ophthalmology~~.~~;

(M) Oral surgery~~.~~;

(N) Orthopedic surgery~~.~~;

(O) Otorhinolaryngology~~.~~;

(P) Plastic surgery~~.~~;

(Q) Pharmacy consulting services~~.~~;

(R) Podiatry~~.~~;

(S) Psychiatry~~.~~;

(T) Pulmonary disease~~.~~;

(U) Radiology~~.~~;

(V) Rheumatology~~.~~;

(W) General surgery~~.~~;

(X) Thoracic and vascular surgery~~.~~; and

(Y) Urology.

(12) Laboratory tests, x-rays, and other diagnostic procedures~~.~~;

(13) Drugs and biologicals~~.~~;

(14) Prosthetics, orthotics, ~~durable medical equipment,~~medical supplies, equipment, and appliances, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items~~.~~;

(15) Acute inpatient care, including the following:

(A) Ambulance~~.~~;

(B) Emergency room care and treatment room services~~.~~;

(C) Semi-private room and board~~.~~;

(D) General medical and nursing services~~.~~;

(E) Medical surgical/intensive care/coronary care unit~~.~~;

(F) Laboratory tests, x-rays, and other diagnostic procedures~~.~~;

(G) Drugs and biologicals~~.~~;

(H) Blood and blood derivatives~~.~~;

(I) Surgical care, including the use of anesthesia~~.~~;

(J) Use of oxygen~~.~~;

(K) Physical, occupational, respiratory therapies, and speech-language pathology services~~.~~; and

(L) Social services.

(16) Nursing facility (NF) care, including:

(A) Semi-private room and board;

(B) Physician and skilled nursing services;

(C) Custodial care;

(D) Personal care and assistance;

(E) Drugs and biologicals;

(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;

(G) Social services; and

(H) Medical supplies, equipment, and appliances.

(17) Other services determined necessary by the ~~interdisciplinary team~~IDT to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:

(1) Any service that is not authorized by the ~~interdisciplinary team,~~IDT, even if it is a required service, unless it is an emergency service.

(2) In an inpatient facility, private room and private duty nursing (PDN) services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the ~~interdisciplinary team~~IDT as part of the participant's plan of care).

(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

(4) Experimental medical, surgical, or other health procedures.
(5) Services furnished outside of the United States, except as follows:
(A) ~~in~~In accordance with 42 ~~CFR~~C.F.R. § 424.122 through 42 ~~CFR~~ C.F.R. § 424.124, and
(B) ~~as~~As permitted under the State's approved Medicaid ~~plan.~~State Plan.

(c) In the event that a PACE participant is in need of permanent placement in a ~~nursing facility,~~NF, a Medicaid premium will be imposed. OKDHS will calculate a vendor co-payment for those participants using the same methodology as is used for any Oklahoma Medicaid member who is accessing ~~nursing facility~~NF level of care. However, for a PACE participant, the ~~participants~~participant's responsibility will be to make payment directly to the PACE provider~~.~~, the amount to be specified by the OKDHS worker. There are no other share of costs requirements for PACE.

(d) All PACE ~~Program Benefits~~program benefits are offered through the duration of the PACE participant's enrollment in the PACE program. PACE enrollment does not cease once a participant's condition necessitates or the PACE IDT recommends that ~~they~~he or she be institutionalized.

E-2.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND ~~COMMUNITY BASED SERVICES WAIVERS~~COMMUNITY-BASED WAIVER SERVICES
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES
317:50-1-14 [AMENDED]
(Reference APA WF # 20-06D)

317:50-1-14. Description of services

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

(1) **Case Management.**

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

(B) Providers may only claim time for billable case management activities described as follows:

(i) A billable case management activity is any task or function defined under ~~OAC~~Oklahoma Administrative Code (OAC) 317:50-1-15(1)(A), that only a Medically Fragile case manager because of skill, training, or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time, or supervisory/administrative activities are not billable case management activities, although the administrative

cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

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

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

(ii) ~~Very rural/difficult service area rate:~~ Case management services are billed using a very ~~rural/difficult~~rural/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An exception would be services to members that reside in ~~OHCA identified~~OHCA-identified zip codes in Osage county adjacent to metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

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

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

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

(2) **Institutional transitional case management.**

(A) Institutional Transition case management services are required by the member's service plan, which are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Institutional transition case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other state

plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility~~.~~ (NF). Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

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

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

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

(4) **Environmental ~~Modifications.~~modifications.**~~—~~

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

(B) All services require prior authorization.

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

(D) Payment for these services is made on an individual basis

following a uniform process approved by the Medicaid agency.

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

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

(B) ~~Specialized medical equipment and supplies~~Medical supplies, equipment, and supplies are billed using the appropriate ~~HCPC~~healthcare common procedure code~~.~~ (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for ~~Waiver~~waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled ~~nursing facility~~(NF) or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for ~~medical supplies~~medical supplies, equipment, and supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented ~~Manufacturer's Suggested Retail Price~~manufacturer's suggested retail price (MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two~~.~~ (2). OHCA may establish a fair market price through claims review and analysis.

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

(A) Advanced ~~Supportive/Restorative Assistance~~supportive/restorative assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

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

(7) **Nursing.**

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.
(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

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

(I) the 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 (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This

service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing 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 fifteeen (15) minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third (1/3) of the recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of

units a member is allowed to receive is limited on the member's service plan. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

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

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

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed

physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

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

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

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education

and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing

Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile hospice services.

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

(14) **Personal Care.**

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

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a case manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Personal Care services are prior authorized and billed per fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

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

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

(i) ~~a~~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~~Lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) ~~demonstrates~~Demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) ~~has~~Has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) ~~has~~Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) ~~the~~The service avoids premature or unnecessary institutionalization of the member.

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

(16) **Prescription drugs.** Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 317:30-5-72.

(17) **Self-Direction.**

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

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

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

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

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

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

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

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

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer able to participate in the Self-Directed services option:

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

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

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

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

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

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

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

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized

representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's case manager or the OHCA staff.

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

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

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the ~~Respite~~respite or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with state and federal labor law requirements. The member:

(i) ~~recruits~~Recruits, hires and, as necessary, discharges the PCA and ASR;

(ii) ~~provides~~Provides instruction and training to the PCA or ASR on tasks to be done and works with the case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR provider task for the first time, the ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASR provider personnel file;

(iii) ~~determines~~Determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;

(iv) ~~supervises~~Supervises and documents employee work time; and~~,~~

(v) ~~provides~~Provides tools and materials for work to be accomplished.

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

(i) ~~employer~~Employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PCA or ASR provider;

(ii) ~~other~~Other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;

(iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;

(iv) ~~providing~~Providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's respite or PCA or ASR provider; and

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

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the IBA expenditure accounts determination process for each member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

(i) The IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including worker's compensation insurance, if available) is determined individually for each member using the Self-Directed services IBA expenditure accounts determination process.

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

(18) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's service plan.

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

(19) **Transitional case management.**

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

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

(C) Transitional case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

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

F.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION
317:30-3-25 [AMENDED]
(Reference APA WF # 20-11)

317:30-3-25. Crossovers ~~(coinsurance and deductible)~~ (deductibles, coinsurance, and copays)

(a) **Medicare Part ~~B~~A.** Payment is made for Medicare ~~deductible and coinsurance~~deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

(b) **Medicare Part ~~A~~B.** Payment is made for Medicare ~~deductible and coinsurance~~deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

~~(c) **Medicare Advantage Plans.** Payment is made for Medicare HMO co-payments. For services offered by Medicare Advantage Plans that revert to traditional Medicare type benefits, payment is made for coinsurance and deductibles according to subsection (a) and (b) in this section.~~

(c) **Medicare Part C (Medicare Advantage Plans).** Payment is made for Medicare deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

G.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

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

317:35-18-5 [AMENDED]

317:35-18-7 [AMENDED]

(Reference APA WF # 20-22)

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in Programs of All-Inclusive Care for the Elderly (PACE), the applicant must:

(1) ~~be~~Be age fifty-five (55) years or older;

(2) ~~live~~Live in a PACE service area;

(3) ~~be~~Be determined by the state to meet nursing facility level of care; and

(4) ~~be~~Be determined by the PACE interdisciplinary team (IDT) as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) ~~notify~~Notify the applicant in writing of the reason for the denial;

(B) ~~refer~~Refer the applicant to alternative services as appropriate;

(C) ~~maintain~~Maintain supporting documentation for the denial and notify the Centers for Medicare and Medicaid Services and the Oklahoma Health Care Authority (OHCA) of the denial and ~~make the supporting documentation available for review; and~~submit that documentation to the OHCA for review; and

(D) ~~advise~~Advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:

(1) ~~meet~~Meet categorical relationship for the aged, blind, or disabled [refer to Oklahoma Administrative Code (OAC) 317:35-5-4];

(2) ~~be~~Be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services (DHS);

(3) ~~be~~Be eligible for SoonerCare State Plan services;

(4) ~~meet~~Meet the same financial eligibility criteria as set forth for the SoonerCare ADvantage program per OAC 317:35-17-10 and 317:30-17-11; and

(5) ~~meet~~Meet appropriate medical eligibility criteria.

(c) The nurse designee makes the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) Part I, Part III, and other available medical information.

(1) When PACE services are requested:

(A) The PACE nurse or DHS nurse is responsible for completing the UCAT assessment.

(B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting DHS to initiate the financial eligibility application process.

(2) The nurse completes the UCAT, Part III visit with the PACE enrollee, in the participant's home, within ten (10) days of receipt of the referral for PACE services.

(3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.

(4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:

(A) ~~from~~From PACE to ADvantage;

(B) ~~from~~From PACE to State Plan Personal Care Services;

(C) ~~from~~From Nursing Facility to PACE;

(D) ~~from~~From ADvantage to PACE if previous UCAT was completed more than six (6) months prior to member requesting PACE enrollment; or

(E) ~~from~~From PACE site to PACE site.

(d) To obtain and maintain eligibility, the individual must agree to accept the PACE providers and its contractors as the individual's only service provider. The individual may be held financially liable for services received without prior authorization except for emergency medical care.

317:35-18-7. PACE organization's ~~Appeals~~appeals process

(a) Internal appeals

(1) Any individual who is denied program services is entitled to an appeal through the provider.

(2) If the individual also chooses to file an external appeal, the provider must assist the individual in filing an external appeal.

(b) External appeals may be filed through the OHCA legal division and follow the process outlined in OAC 317:2-1-2.

(c) Expedited appeals process (refer to 42 CFR § 460.122).

(1) A PACE organization must have an expedited appeals process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the service in dispute.

(2) Except as provided in paragraph (c)(3) of this section, the PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than seventy-two (72) hours after it receives the appeal.

(3) The PACE organization may extend the seventy-two (72) hour timeframe by up to fourteen (14) calendar days for either of the following reasons:

(A) The participant requests the extension; or

(B) The organization justifies to the State administering agency (OHCA) the need for additional information and how the delay is in the interest of the participant.

(4) Supporting documentation must be submitted to (OHCA) once it has been determined that they will be unable to respond to the

appeal within the seventy-two (72) hour timeframe.

H.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS
317:40-1-1 [AMENDED]
317:40-1-4 [NEW]
SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES
317:40-5-3 [AMENDED]
317:40-5-5 [AMENDED]
PART 3. GUIDELINES TO STAFF
317:40-5-40 [AMENDED]
PART 9. SERVICE PROVISIONS
317:40-5-100 [AMENDED]
PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS
317:40-5-152 [AMENDED]
SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS
317:40-7-11 [AMENDED]
(Reference APA WF # 20-23)

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Applicability.** This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

(1) ~~accessing,~~Accessing with the Oklahoma Department of Human Services ~~(DHS)~~(OKDHS) staff assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under an HCBS Waiver program;

(2) ~~cooperating~~Cooperating in the determination of medical and financial eligibility including prompt reporting of changes in income or resources;

(3) ~~choosing~~Choosing between services provided through an HCBS Waiver or institutional care; and

(4) ~~reporting~~Reporting any changes in address or other contact information to ~~DHS~~OKDHS within ~~30-calendar~~thirty (30) calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one (1) of the Waivers established in (1) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through an HCBS

Waiver are available to Oklahoma residents meeting SoonerCare (Medicaid) eligibility requirements established by law, regulatory authority, and policy within funding available through ~~State~~state or ~~Federal~~federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions, per OAC 317:35-9-5. The applicant:

(A) ~~must~~Must be determined financially eligible for SoonerCare, per OAC 317:35-9-68;

(B) ~~may~~May not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, or residential care home per Section (§) 1-820 of Title 63 of the Oklahoma Statutes (O.S.), ~~(O.S. 63-1-820),~~ or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

(C) ~~may~~May not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without Waiver supports, per OAC 340:100-5-22.2; and

(D) ~~must~~Must also meet other Waiver-specific eligibility criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

(A) ~~meet~~Meet all criteria listed in (c) of this Section; and

(B) ~~be~~Be determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

(C) ~~be~~Be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU);

(D) ~~be 3~~Be three (3) years of age or older;

(E) ~~be~~Be determined by the OHCA LOCEU to meet the ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(F) ~~reside~~Reside in:

(i) ~~the home of~~ a family ~~member or friend;~~A family member's or friend's home;

(ii) ~~his~~His or her own home;

(iii) ~~a DHS~~An OKDHS Child Welfare Services (CWS) foster home; or

(iv) ~~a~~A CWS group home; and

(vii) ~~have~~Have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare (Medicaid) resources available to the individual; and HCBS Waiver resources within the annual per capita Waiver limit, agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid

Services (CMS).

(3) **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

(A) ~~meet~~Meet all criteria listed in (c) of this Section;

(B) ~~be~~Be determined by the SSA to have a disability and a diagnosis of intellectual disability; or

(C) ~~have~~Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by DDS and be covered under the State's alternative disposition plan, adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(D) ~~be~~Be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA LOCEU; and

(E) ~~be 3~~Be three (3) years of age or older; and

(F) ~~be~~Be determined by the OHCA LOCEU, to meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(G) ~~have~~Have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDS director or designee.

(4) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the applicant must:

(A) ~~be~~Be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(B) ~~meet~~Meet all criteria for HCBS Waiver services listed in (c) of this Section; and

(C) ~~be~~Be determined by SSA to have a disability and a diagnosis of intellectual disability; or

(D) ~~have~~Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition, per OAC 317:35-9-45 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(E) ~~have~~Have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(F) ~~meet~~Meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122, as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) ~~a~~A psychological evaluation, by a licensed psychologist that includes:

(i) ~~a~~A full-scale, functional and/or adaptive assessment;

and
(ii) ~~a~~A statement of age of onset of the disability; and
(iii) ~~intelligence~~Intelligence testing that yields a full-scale, intelligence quotient.
(I) Intelligence testing results obtained at ~~16~~sixteen (16) years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between ~~7 to 16~~seven to sixteen (7 to 16) years of age are considered current for four (4) years when the full-scale intelligence quotient is less than ~~40,~~forty (40) and for two (2) years when the intelligence quotient is ~~40~~forty (40) or above.
(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;
(B) ~~a~~A social service summary, current within ~~12~~twelve (12) months of the requested approval date that includes a developmental history; and
(C) ~~a~~A medical evaluation, current within ~~90-calendar days~~one (1) calendar year of the requested approval date; and
(D) ~~a~~A completed Form LTC-300, ICF/IID Level of Care Assessment; and
(E) ~~proof~~Proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.
(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.
(7) **State's alternative disposition plan.** For individuals who are determined to have an intellectual disability or a related condition by DDS per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic reports listed in (2) of this subsection and, on behalf of OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.
(8) **Member's choice.** A determination of need for ICF/IID Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.
(d) **Request list.** When state DDS resources are unavailable to add individuals to services funded through an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.
(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation, per Form 06MP001E, Request for Developmental Disabilities Services, for initial consideration of potential

eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual applicant is removed from the Request for Waiver Services List, when he or she:

(A) ~~is~~Is found to be ineligible for services;

(B) ~~cannot~~Cannot be located by ~~DHS;~~OKDHS;

(C) ~~does~~Does not provide ~~DHS-requested~~OKDHS-requested information or fails to respond;

(D) ~~is~~Is not an Oklahoma resident at the requested Waiver approval date; or

(E) ~~declines~~Declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within ~~45-calendar~~forty-five (45) calendar days. When action is not taken within the required ~~45-calendar~~forty-five (45) calendar days, the applicant may seek resolution, per OAC 340:2-5-61.

(1) Applicants are allowed ~~60-calendar~~sixty (60) calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within ~~60-calendar~~sixty (60) calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List, per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (c) of this Section. Exceptions to the chronological requirement may be made, when:

(1) ~~an~~An emergency situation exists in which the health or safety of the person needing services or of others is endangered and there is no other resolution to the emergency. An emergency exists, when:

(A) ~~the~~The person is unable to care for himself or herself and:

(i) the person's caretaker, ~~per 43A O.S. § 10-103:~~43A O.S.

§ 10-103:

(I) ~~is~~Is hospitalized;

(II) ~~moved~~Moved into a nursing facility;

(III) ~~is~~Is permanently incapacitated; or

(IV) ~~died;~~Died; and

(ii) ~~there~~There is no caretaker to provide needed care to the individual; or

(iii) ~~an~~An eligible person is living at a homeless shelter or on the street;

(B) ~~DHS~~OKDHS finds the person needs protective services due to ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) ~~the~~The behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, when the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) ~~the~~The person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so~~;~~.

(2) ~~the~~The Legislature appropriated special funds with which to serve a specific group or a specific class of individuals, per HCBS Waiver provisions;

(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in ~~DHS~~OKDHS custody receiving services from ~~DHS.~~OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/IID and enters the Waiver; or

(4) ~~individuals~~Individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30-continuous months prior to January 1, 1989, and are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDS HCBS Waiver programs.** A person's movement from services funded through one (1) DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes ~~18~~eighteen (18) years of age, services through the IHSW for adults becomes effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) ~~a~~A member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and

(B) ~~funding~~Funding is available, per OAC 317:35-9-5.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization was within the IHSW per capita allowance.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA LOCEU when a determination of disability was not made by the Social Security Administration. The OHCA LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA LOCEU also approves the level of care, per OAC 317:30-5-122, and confirms a diagnosis of intellectual disability per the Diagnostic and Statistical Manual of Mental Disorders.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf ~~30-calendar~~thirty (30) calendar days prior to the Plan of Care expiration.

(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:

(1) ~~a~~A member or the individual acting on the member's behalf chooses to no longer receive Waiver services;

(2) ~~a~~A member is incarcerated;

(3) ~~a~~A member is financially ineligible to receive Waiver services;

(4) ~~a~~A member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) ~~a~~A member is determined by the OHCA LOCEU to no longer be eligible;

(6) ~~a~~A member moves out of state or the custodial parent or guardian of a member who is a minor moves out of state;

(7) ~~a~~A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than ~~30-consecutive~~thirty (30) consecutive calendar days;

(8) ~~the~~The guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process, per

OAC 340:100-5-50 through 340:100-5-58;
(9) ~~the~~The guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of ~~DHS policy~~the OKDHS rule or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services were not effective;
(10) ~~the~~The member is determined to no longer be SoonerCare eligible;
(11) ~~there~~There is sufficient evidence the member or the individual acting on the member's behalf engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;
(12) ~~the~~The member or the individual acting on the member's behalf either cannot be located, did not respond, or did not allow case management to complete plan development or monitoring activities as required, per OAC 340:100-3-27, and the member or the individual acting on the member's behalf:
(A) ~~does~~Does not respond to the notice of intent to terminate; or
(B) ~~the~~The response prohibits the case manager from being able to complete plan development or monitoring activities as required, per OAC 340:100-3-27;
(13) ~~the~~The member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;
(14) ~~it~~It is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;
(15) ~~the~~The member or the individual acting on the member's behalf fails to cooperate with service delivery;
(16) ~~a~~A family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official ~~DHS~~OKDHS representatives; or
(17) ~~a~~A member no longer receives a minimum of one (1) Waiver service per month and DDS is unable to monitor the member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:
(1) ~~the~~The situation resulting in case closure of a Hissom class member is resolved;
(2) ~~a~~A member is incarcerated for ~~90-calendar~~ninety (90) calendar days or less;
(3) ~~a~~A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for ~~90-calendar~~ninety (90) calendar days or less; or
(4) ~~a~~A member's SoonerCare eligibility is re-established within

~~90-calendar~~ninety (90) calendar days of the SoonerCare ineligibility date.

317:40-1-4. Remote support (RS)

(a) **General Information.** RS services are intended to promote a member's independence. RS services are provided in the member's home, family home, or employment site to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's Individual Plan (Plan) and arrangements for this service are made through the case manager.

(1) RS services are:

(A) Based on the member's needs as documented and supported by the Plan and Person-Centered Assessment;

(B) The least-restrictive option and the member's preferred method to meet an assessed need;

(C) Provided when all adult members of the household; his or her guardians, when applicable; and Personal Support Team (Team) agree to the provision of RS services as documented in the Plan; and

(D) Reviewed by the Team after sixty (60) calendar days of initial installation to determine continued appropriateness of services.

(2) RS services are not a system to provide surveillance or for staff convenience.

(b) **Service description.** RS is monitoring of an adult member; allowing for live, two-way communication with him or her in his or her residence or employment site, by monitoring staff using one or more of the systems in one (1) through eight (8) that are:

(1) Live-video feed;

(2) Live-audio feed;

(3) Motion-sensing monitoring;

(4) Radio-frequency identification;

(5) Web-based monitoring;

(6) Personal Emergency Response System (PERS);

(7) Global positioning system (GPS) monitoring devices; or

(8) Any other device approved by the Developmental Disabilities Services (DDS) director or designee.

(c) **General provider requirements.** RS service providers must have a valid Oklahoma Health Care Authority (OHCA) SoonerCare (Medicaid) provider agreement to provide agency-based RS services to Oklahoma Human Services (OKDHS) DDS Home-and-Community Based Services (HCBS) Waiver members. Requests for applications to provide RS are made to and approved by OKDHS DDS state office.

(1) An RS assessment is completed:

(A) Annually;

(B) Prior to RS implementation; and

(C) As required by ongoing progress and needs assessments.

(2) Each member is required to identify at least two emergency response staff. The member's emergency response staff are documented in his or her Plan.

(3) RS observation sites are not located in a member's

residence.
(4) The use of camera or video equipment in the member's bedroom or other private area is prohibited.
(5) RS services are provided in real time by awake staff at a monitoring base using the appropriate connection, not by a recording. While RS is provided the RS staff does not have duties other than remote supports.
(6) RS equipment used in the member's residence includes a visual indicator to the member that the system is on and operating.
(7) RS provider agencies must immediately notify in writing, the member's residential provider agency, vocational provider agency, assigned DDS case manager, or guardian of activity in the household, who could potentially compromise the member's health or safety.
(8) Emergency response provider agency staff records are maintained, per Oklahoma Administrative Code (OAC) 340:100-3-40.
(9) RS provider records are maintained for seven (7) calendar years or until any pending litigation involving the service recipient is completed, whichever occurs last and include at a minimum:
(A) The member's name;
(B) The staff's name who delivered the service;
(C) Service dates;
(D) Service begin and end times;
(E) Provider's location;
(F) Description of services provided or observation note;
(G) Method of contact with member; and
(H) The member's current photograph.
(10) RS providers must have:
(A) Safeguards in place including, but not limited to:
(i) A battery or generator to insure continued coverage during an electrical outage at the member's home and monitoring facility;
(ii) Back-up procedures at the member's home and monitoring site for:
(I) Prolonged power outage;
(II) Fire;
(III) Severe weather; and
(IV) The member's personal emergency.
(iii) The ability to receive alarm notifications, such as home security, smoke, or carbon monoxide at each residence monitored, as assessed by the team as necessary for health and safety.
(B) Two-way audio communication allowing staff monitors to effectively interact with, and address the member's needs in each residence;
(C) A secure Health Insurance Portability and Accountability Act (HIPAA)-compliant network system requiring data authentication, authorization, and encryption to ensure access to computer vision, audio, sensor, or written information is limited to authorized staff or team members

per the Plan;
(D) A current file for each member receiving RS services including:
(i) The member's photograph;
(ii) The member's Plan;
(iii) The member's demographics; and
(iv) Any other pertinent data to ensure the member's safety.
(E) Capability to maintain all video and make it available to OKDHS staff upon request for a minimum of twelve (12) calendar months. OKDHS may require an extended timeframe when necessary.

(d) **RS staff requirements.** RS staff:
(1) May not have any assigned duties other than oversight and member support at the time they are monitoring;
(2) Receive member specific training per the member's Plan prior to providing support to a member;
(3) Assess urgent situations at a member's home or employment site and call 911 first when deemed necessary; then contact the member's residential provider agency or employment provider agency designated emergency response staff; or the member's natural support designated emergency response person while maintaining contact with the member until persons contacted or emergency response personnel arrive on site;
(4) Implement the member's Plan as written by the Team and document the member's status at least hourly;
(5) Complete and submit incident reports, per OAC 340:100-3-34, unless emergency backup staff is engaged;
(6) Provide simultaneous support to no more than sixteen (16) members;
(7) Are eighteen (18) years of age and older; and
(8) Are employed by an approved RS agency.

(e) **Emergency response requirement.**
(1) Emergency response staff are employed by a provider agency with a valid OHCA SoonerCare (Medicaid) provider agreement to provide residential services, vocational services or habilitation training specialist (HTS) services to OKDHS/DDS HCBS Waiver members and:
(A) May not have any assigned duties other than oversight and support of members at the time they are assigned as response staff;
(B) Receive all trainings required, per OAC 340:100-3-38.1, for members in residential settings; OAC 340:100-3-38.2 for members in employment settings; or OAC 340:100-3-38.3, for members in non-residential settings per the Plan prior to providing support;
(C) Provide a response on site at the member’s residence or employment site within twenty (20) minutes when contacted by RS staff unless a shorter timeframe is indicated in the member's Plan;
(D) Have an on-call back-up person who responds when the primary response staff engaged at another home or employment

site is unable to respond within the specified time frame;
(E) Provide written or verbal acknowledgement of a request for assistance from the RS staff;
(F) Complete and document emergency drills with the member quarterly when services are provided in the member's home;
(G) Implement the Plan as written and document each time they are contacted to respond, including the nature of the intervention and the duration;
(H) Complete incident reports, per OAC 340:100-3-34; and
(I) Are eighteen (18) years of age and older.

(2) Natural emergency response persons:
(A) Are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member's Team;
(B) Are available to respond in the case of an emergency within twenty (20) minutes from the time they are contacted by RS staff, unless a shorter response time is indicated in the Plan;
(C) Have an on-call back-up person who responds when the primary response staff is unable to respond within the specified time frame;
(D) Provide written or verbal acknowledgement of a request for assistance from the remote support staff; and
(E) Are eighteen (18) years of age and older.

(f) **Service limitations.** RS is limited to twenty-four (24) hours per day. RS is not provided simultaneously with HTS services, homemaker services, agency companion services, group home services, specialized foster care, respite, intensive personal supports services, group job coaching, or where foster care is provided to children. RS can be provided in conjunction with daily living supports, individual job coaching, employment stabilization services, and center and community based services.

(1) Services not covered include, but are not limited to:
(A) Direct care staff monitoring;
(B) Services to persons under the age of eighteen (18); or
(C) Services provided in any setting other than the member's primary residence or employment site.

(2) RS services are shared among OKDHS/DDS Waiver members of the same household in a residential setting. RS provider agencies may only bill for one (1) member of a household at a time. Only one (1) remote support provider per household;

(3) Assistive technology purchases are authorized, per OAC 317:40-5-100.

(g) **RS Discontinuation.** The member and his or her Team determine when it is appropriate to discontinue RS services. When RS services are terminated, the RS provider agency coordinates termination of service with the member's residential provider agency or vocational provider agency and Team to ensure a safe transition. When a member requests the termination of RS services while RS is being provided, the RS staff:

(1) Notifies the provider to request an emergency response staff;

(2) Leaves the system operating until the emergency response staff arrives; and
(3) Turns off the system once relieved by the emergency response staff.

SUBCHAPTER 5. MEMEBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services (ACS)

(a) ~~Agency companion services (ACS)~~ACS are:
(1) ~~provided~~Provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);
(2) ~~provided by~~Provider Agency independent contractors ~~of the provider agency~~ and provide a shared living arrangement developed to meet the member's specific needs ~~of the member~~ that ~~includes~~include supervision, supportive assistance, and training in daily living skills, and integrates the member into the shared experiences of a family in a home owned or rented by the companion;
(3) ~~available~~Available to members ~~18~~eighteen (18) years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under ~~18~~eighteen (18) years of age may be served with approval from the Oklahoma Department of Human Services Developmental Disabilities Services (DDS) director or designee;
(4) ~~based~~Based on the member's need for residential services, per Oklahoma Administrative Code(OAC) 340:100-5-22, and support as described in the member's Individual Plan (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:
(1) ~~must~~Must have an approved home profile, per OAC 317:40-5-3, and contract with a ~~provider contract with a~~DDS-approved provider agency ~~approved by DDS~~;
(2) ~~may~~May provide companion services for one (1) member. Exceptions to serve as companion for two (2) members may be approved by the DDS director or designee. Exceptions for up to two(2) members may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two (2) members~~;~~. Exceptions for additional members may be granted when the DDS director or designee determines an emergency situation exists and there is no other resolution, and the companion demonstrates the skill and ability required to serve as a companion.
(3) ~~household~~Household is limited to one (1) individual companion provider. Exceptions for two (2) individual companion providers in a household who each provide companion services to different members may be approved by the DDS director or designee;

(4) ~~may~~May not provide companion services to more than two (2) members at any time;
(5) ~~household~~Household may not simultaneously serve more than ~~three~~four (4) members through any combination of companion or respite services~~;~~.
(6) ~~may~~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.
(A) The companion may have employment when:
~~(i) personal support team (Team) documents and addresses all related concerns in the member's Plan;~~
~~(ii) employment is approved in advance by the DDS area manager or designee; and~~
(i) Employment is approved in advance by the DDS area residential services program manager;
~~(iii) companion's~~(ii) Companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and
~~(iv) companion~~(iii) Companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.
(B) If, after receiving approval for employment, authorized DDS staff determines the employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within ~~30~~thirty (30) calendar days:
(i) ~~his~~His or her employment; or
(ii) ~~his~~His or her contract as an agency companion.
(C) Homemaker, habilitation training specialist, and respite services are not provided for the companion to maintain ~~other~~ employment.
(c) Each member may receive up to ~~60~~sixty (60) calendar days per year of therapeutic leave without reduction in the agency companion's payment.
(1) Therapeutic leave:
(A) ~~is~~Is a SoonerCare (Medicaid) payment made to the contract provider to enable the member to retain services; and
(B) ~~is~~Is claimed when the:
(i) ~~member~~Member does not receive ACS for ~~24~~twenty-four (24) consecutive hours due to:
(I) ~~a~~A visit with family or friends without the companion;
(II) ~~vacation~~Vacation without the companion; or
(III) ~~hospitalization,~~Hospitalization, regardless of whether the companion is present; or
(ii) ~~companion~~Companion uses authorized respite time;
(C) ~~is~~Is limited to no more than ~~14~~fourteen (14) consecutive, calendar days per event, not to exceed ~~60~~sixty (60) days per Plan of Care (POC) year; and
(D) ~~cannot~~Cannot be carried over from one (1) POC year to the

next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate ~~except for the pervasive rate that is paid at the enhanced agency companion per diem rate~~.

(3) The provider agency pays the agency companion the payment he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to ~~660~~seven-hundred and twenty (720) hours.

(e) Habilitation Training Specialist (HTS) services:

(1) ~~may~~May be approved by the DDS director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:

(A) ~~sleeping~~Sleeping at night; or

(B) ~~working~~Working or attending employment, educational, or day services;

(2) ~~may~~May be approved when a time-limited situation exists in which the companion provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) ~~must~~Must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers; and

(4) ~~must~~Must be documented by the Team and the Team must continue efforts to resolve the need for HTS.

(f) The contractor model does not include funding for the provider agency for the provision of benefits to the companion.

(g) The agency receives a daily rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) ~~determined~~Determined by authorized DDS staff per levels described in (A) through(D); and

(2) ~~re-evaluated~~Re-evaluated when the member has a change in agency companion providers that includes a change in ~~agencies or~~ individual companion providers.

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

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

(ii) ~~may~~May be able to spend short periods of time unsupervised inside and outside the home; and

(iii) ~~requires~~Requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member ~~requires:~~requires the level of assistance outlined in (g)(2)(A) and at least two (2) of the following:

(i) ~~regular,~~Regular frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;
(ii) ~~extensive~~Extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; ~~and~~or
(iii) ~~assistance~~Assitance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the ~~member:~~member requires the level of assistance outlined in (g)(2)(B) and at least one (1) of the following:

(i) ~~is~~Is totally dependent on others for:
(I) ~~completion~~Completion of daily living skills, such as bathing, dressing, eating, and toileting; and
(II) ~~medication~~Medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) ~~demonstrates~~Demonstrates ongoing complex medical issues requiring specialized training courses, per OAC 340:100-5-26; or

(iii) ~~has~~Has behavioral issues that requires a protective intervention ~~plan~~protocol (PIP) with a restrictive or intrusive procedure, per OAC 340:100-1-2. The PIP must:
(I) ~~be~~Be approved by the Statewide Human Rights Behavior Review Committee ~~(SBRC),~~(SHRBRC), per OAC 340:100-3-14; or
~~(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or~~
~~(III)~~(II) ~~have~~Have received expedited approval, per OAC 340:100-5-57~~.~~;

(iv) Meets the requirements of (g)(2)(C)(i) through (iv); and 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.

(D) **Pervasive level of support.** Pervasive level of support requires the level of assistance outlined in (g)(2)(C), and is authorized when the member:

(i) ~~requires~~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~~By a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

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

(III) As part of the ACS and not billed as a separate service. Waiver services may be authorized for the development of a PIP, per OAC 340:100-5-57; and

(ii) ~~does~~Does not have an available personal support system. The need for this service level:

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

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

(h) Authorization for payment of ~~Agency Companion Service~~ACS is contingent upon receipt of:

(1) ~~the~~The applicant's approval letter authorizing ACS for the identified member;

(2) ~~an~~An approved relief and emergency back-up plan addressing a back-up location and provider;

(3) ~~the~~The Plan;

(4) ~~the~~The POC; and

(5) ~~the~~The date the member ~~moved~~is scheduled to move to the ~~companion~~companions home. When a member transitions from a DDS placement funded by a pier diem the incoming provider may request eight (8) hours of HTS for the first day of service.

(i) The Plan reflects the amount of room and board the member pays to the companion. The provider must use the room and board reimbursement payment to meet the member's needs. Items purchased with the room and board reimbursement payment include housing and food.

(j) ~~If the amount exceeds $500, the additional amount must be:~~

~~(1) agreed upon by the member and, when applicable, legal guardian;~~

~~(2) recommended by the Team; and~~

~~(3) approved by the DDS area manager or designee.~~The room and board payment may include all but one-hundred and fifty dollars ($150) per month of the service recipient's income, up to a maximum of ninety (90) percent of the current minimum Supplemental Security Income (SSI) payment for a single individual.

317:40-5-5. Agency ~~Companion Services~~companion services (ACS) provider responsibilities

(a) Companions are required to meet all applicable standards outlined in this subchapter and competency-based training per Oklahoma Administrative Code (OAC) 340:100-3-38. The provider agency ensures all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and

when warranted, revocation of approval of the companion.

(c) The companion:

(1) ~~ensures~~Ensures no other adult or child is cared for in the home on a regular or part-time basis, including other Oklahoma Department of Human Services ~~(DHS)~~(OKDHS) placements, family members, or friends without prior written authorization from the Developmental Disabilities Services ~~Division~~ (DDS) area residential services programs manager or ~~designee;~~state office residential services programs manager;

(2) ~~meets~~Meets the requirements of OAC 317:40-5-103. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) ~~transports~~Transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) ~~delivers~~Delivers services in a manner that contributes to the member's enhanced independence, self-sufficiency, community inclusion, and well-being;

(5) ~~participates~~Participates as a member of the member's Team and assists in the development of the member's Individual Plan(Plan) for service provision;

(6) ~~develops,~~Develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan. The companion may request assistance from the case manager or program coordinator. The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff~~.~~;

(7) ~~delivers~~Delivers services at appropriate times as directed in the Plan;

(8) ~~does~~Does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);

(9) ~~is~~Is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;

(10) ~~participates~~Participates in, and supports visitation and contact with the member's natural family, guardian, and friends, when visitation is desired by the member;

(11) ~~obtains~~Obtains permission from the member's legal guardian, a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) ~~traveling out of state;~~Traveling out-of-state;

(B) ~~overnight~~Overnight visits; or

(C) ~~involvement~~Involvement of the member in any publicity;

(12) ~~serves~~Serves as the member's health care coordinator, per OAC 340:100-5-26;

(13) ~~ensures~~Ensures the monthly room and board contribution received from the member is used toward the cost of operating the household;

(14) ~~assists~~Assist the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;
(15) ~~works~~Works closely with the provider agency program coordination staff and the DDS case manager, to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;
(16) ~~assists~~Assist the member to achieve the member's maximum level of independence;
(17) ~~submits,~~Submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;
(18) ~~ensures~~Ensures the member's confidentiality is maintained per, OAC 340:100-3-2;
(19) ~~supports~~Supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) ~~implements~~Implements training and provides supports that enable the member to actively join in community life;
(21) ~~does~~Does not serve as representative payee for the member without a written exception from the DDS area residential services programs manager or ~~designee.~~state office residential services program manager
   (A) ~~The~~The written exception ~~is~~and approved DDS home profile are retained in the member's home record.
   (B) ~~When~~When serving as payee, the companion complies with OAC 340:100-3-4 requirements;
(22) ~~ensures~~Ensures the member's funds are properly safeguarded;
(23) ~~obtains~~Obtains prior approval from the member's representative payee when making a purchase of over ~~$50~~fifty dollars ($50) with the member's funds;
(24) ~~allows~~Allows provider agency and DDS staff to make announced and unannounced visits to the home;
(25) ~~develops~~Develops an Evacuation Plan, using ~~DHS~~(OKDHS) Form 06AC020E, Evacuation/Escape Plan, for the home and conducts training with the member;
(26) ~~conducts~~Conducts fire and weather drills at least quarterly and documents the fire and weather drills using OKDHS Form 06AC021E, Fire and Weather Drill Record;
(27) ~~develops~~Develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using OKDHS Form 06AC022E, Personal Possession Inventory;
(28) ~~supports~~Supports the member's employment program by:
   (A) ~~assisting~~Assisting the member to wear appropriate work attire; and
   (B) ~~contacting~~Contacting the member's employer as outlined by the Team and in the Plan;
(29) ~~is~~Is responsible for the cost of the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;

(30) ~~for~~For adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, ~~and/or~~or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes, to the ~~DHS~~OKDHS Office of Client Advocacy (OCA);
(31) ~~for~~For children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511;
(32) ~~follows~~Follows all applicable rules promulgated by the Oklahoma Health Care Authority and DDS, including:
~~(A) OAC 340:100-3-40;~~
~~(B) OAC 340:100-5-50 through 100-5-58;~~
~~(C) OAC 340:100-5-26;~~
~~(D) OAC 340:100-5-34;~~340:100-5-33;
~~(E) OAC 340:100-5-32;~~
~~(F) OAC 340:100-5-22.1;~~
~~(G) OAC 340:100-3-27;~~
~~(H) OAC 340:100-3-38; and~~
~~(I) OAC 340:100-3-34;~~
(A) OAC 340:100-3-27;
(B) OAC 340:100-3-34;
(C) OAC 340:100-3-38;
(D) OAC 340:100-3-40;
(E) OAC 340:100-5-22.1;
(F) OAC 340:100-5-26;
(G) OAC 340:100-5-32;
(H) OAC 340:100-5-33; and
(I) OAC 340:100-5-50 through 340:100-5-58.
(33) ~~is~~Is neither the member's spouse, nor when the member is a minor child, the member's parent. A family member servicing as companion must meet all requirements listed in this Subchapter; and
(34) ~~is~~Is not the Chief Executive Officer of a provider agency.

PART 3. GUIDELINES TO STAFF

317:40-5-40. Home profile process 1 & 2

(a) **Applicability.** This Section establishes procedures for the Developmental Disabilities Services (DDS) home profile process. A home profile is required for:
(1) ~~agency~~Agency companion services (ACS);
(2) ~~specialized~~Specialized foster care (SFC) services;
(3) ~~respite~~Respite services delivered in the provider's home;
(4) ~~approving~~Approving services in a home shared by a non-relative provider and a member; and
(5) ~~any~~Any other situation that requires a home profile.
(b) **Pre-screening.** Designated ~~(DDS)~~DDS staff provides the applicant with program orientation and completes pre-screening ~~information that includes, but is~~activities to include, but are not limited to:

(1) ~~facts,~~Facts description, and guiding principles of the Home and Community-Based Services (HCBS) program;
(2) ~~an~~An explanation of:
(A) ~~the~~The home profile process;
(B) ~~basic~~Basic provider qualifications;
(C) ~~health,~~Health, safety, and environmental issues; and
(D) ~~training~~Training required per Oklahoma Administrative Code (OAC) 340:100-3-38;
(3) ~~the Oklahoma Department of Human Services (DHS) Form 06AC012E, Specialized Foster Care/Agency Companion Services Information Sheet;~~Gathering relevant information about the family, including household members, addresses, and contact information, and motivation to provide services; and
(4) ~~explanation~~An explanation of a background investigation conducted on the applicant and any adult or child living in the applicant's home.
(A) Background investigations are conducted at the time of application and include, but are not limited to:
(i) ~~an~~An Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety (DPS), Sex Offender Registry, ~~and~~ Mary Rippy Violent Offender Registries~~;~~, and Nurse Aide and Non-technical Services Worker Registry;
(ii) Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant and any adult members of the household; except when an exception is necessary as outlined below.
(I) When fingerprints are low quality (as determined by OSBI, FBI, or both) and make it impossible for the national crime information databases to provide results, a name-based search (state, national, or both) may be authorized.
(II) When the DDS State Office residential staff request an exception from an individual, who has a severe physical condition precluding the individual from being fingerprinted, a name-based search (state, national, or both) may be authorized.
(iii) ~~search~~Search of any involvement as a party in a court action;
(iv) ~~search~~Search of all ~~DHS~~OKDHS records, ~~and the~~ Community Services Worker Registry~~;~~, and Restricted Registry;
(v) ~~a~~A search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived in Oklahoma continuously for the past five (5) years. A home is not approved without the results of the out-of-state ~~maintained~~ child abuse and neglect registry checks, when a registry is maintained in the applicable state, for all adult household members living in the home. When a child abuse and neglect registry is not maintained in the

applicable state, a request for information is made to the applicable state; and

(vi) ~~search~~Search of Juvenile Justice Information System (JOLTS) records for any child older than ~~13~~thirteen (13) years of age in the applicant's household.

(B) An application is denied when the applicant or any person residing in the applicant's home:

(i) ~~has~~Has a criminal conviction of or pled guilty or no contest to:

(I) ~~physical~~Physical assault, battery, or a drug-related offense in the five-year period preceding the application date;

(II) ~~child~~Child abuse or neglect;

(III) ~~domestic~~Domestic abuse;

(IV) ~~a~~A crime against a child, including, but not limited to, child pornography;

(V) ~~a~~ crime involving violence, including, but not limited to, rape, sexual assault, or homicide, including manslaughter, excluding physical assault and battery; or

(ii) ~~does~~Does not meet OAC 340:100-3-39 requirements;

~~(5) DHS Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;~~

~~(6) DHS Form 06AC016E, DDS Reference Information Waiver;~~

~~(7) DHS Form 06AC029E, Employer Reference Letter; and~~

~~(8) DHS Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.~~

(c) **Home profile process.** When the applicant meets the requirements of the prescreening, the initial home profile process described in (1) through (8) of this subsection is initiated.

(1) The applicant ~~completes the required forms and returns the forms to the DDS address provided. Required forms include DHS Forms:~~provides required information for the completion of the home profile.

~~(A) 06AC008E, Specialized Foster Care/Agency Companion Services Application;~~

~~(B) 06AC009E, Financial Assessment;~~

~~(C) 06AC011E, Family Health History;~~

~~(D) 06AC018E, Self Study Questionnaire;~~

~~(E) 06AC019E, Child's Questionnaire;~~

~~(F) 06AC010E, Medical Examination Report, when Form 06AC011E indicates conditions that may interfere with the provision of services;~~

~~(G) 06AC017E, Insurance Information; and~~

~~(H) 06AC020E, Evacuation/Escape Plan.~~

(2) When an incomplete form or other information is returned to DDS, designated DDS staff sends a letter to the provider or provider agency identifying information needed to complete the required forms. The home profile is not completed until all required information is provided to DDS.

(3) Designated DDS staff completes the home profile when all required forms are completed and provided to DDS.

(4) For each reference provided by the applicant, designated DDS staff ~~completes DHS Form 06AC058E, Reference Letter;~~documents the results of each completed reference check.

(5) Designated DDS staff, through interviews, visits, and phone calls, gathers information required to complete ~~DHS Form 06AC047E, Home Profile Notes.~~the home profile.

(6) ~~DHS Form 06AC069E, Review of Policies and Areas of Responsibilities, is dated and signed~~DDS staff review policies and areas of responsibilities with the applicant and acknowledgement is made in writing by the applicant and designated DDS staff.

(7) The DDS area residential services programs manager sends to the applicant:

(A) ~~a~~A provider approval letter confirming the applicant is approved to serve as a provider; or

(B) ~~a~~A denial letter stating the application and home profile are denied.

(8) DDS staff records the dates of completion of each part of the home profile process.

(d) **Home standards.** In order to qualify and remain in compliance, the applicant's or provider's home must meet the provisions in (1) through (11) of this subsection.

(1) **General conditions.**

(A) The home, buildings, and furnishings must be comfortable, clean, and in good repair and the grounds must be maintained. There must be no accumulation of garbage, debris, or rubbish or offensive odors.

(B) The home must:

(i) ~~be~~Be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed;

(ii) ~~have~~Have adequate heating, cooling and plumbing; and

(iii) ~~provide~~Provide space for the member's personal possessions and privacy;

(iv) ~~allow~~Allow adequate space for the recreational and social needs of the occupants.

(C) Provisions for the member's safety must be present, as needed, including:

(i) ~~guards~~Guards and rails on stairways;

(ii) ~~wheelchair~~Wheelchair ramps;

(iii) ~~widened~~Widened doorways;

(iv) ~~grab~~Grab bars;

(v) ~~adequate~~Adequate lighting;

(vi) ~~anti-scald~~Anti-scald devices; and

(vii) ~~heat~~Heat and air conditioning equipment guarded and installed in accordance with manufacturer requirements. Home modifications and equipment may be provided through HCBS Waivers operated by DDS.

(D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas must be equipped with sufficient

safety barriers or devices designed to prevent accidental injury or unsupervised access.

(E) The household must be covered by homeowner's or renter's insurance including personal liability insurance.

(2) **Sanitation.**

(A) Sanitary facilities must be adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) When a septic tank or other non-municipal sewage disposal system is used, it must be in good working order.

(C) Garbage and refuse must be stored in readily cleanable containers, pending weekly removal.

(D) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards.

(i) Proof of rabies or other vaccinations as required by a licensed veterinarian for household pets must be maintained on the premises.

(ii) Pets not confined in enclosures must be under control and not present a danger to members or guests.

(E) There must be adequate control of insects and rodents, including screens used for ventilation in good repair on doors and windows.

(F) Universal precautions for infection control must be followed in care to the member. Hands and other skin surfaces must be washed immediately and thoroughly when contaminated with blood or other body fluids.

(G) Laundry equipment, if in the home, must be located in a safe, well-ventilated, and clean area, with the dryer vented to the outside.

(3) **Bathrooms.** A bathroom must:

(A) ~~provide~~Provide for individual privacy and have a finished interior;

(B) ~~be~~Be clean and free of objectionable odors; and

(C) ~~have~~Have a bathtub or shower, flush toilet, and sink in good repair, and hot and cold water in sufficient supply to meet the member's hygiene needs.

(i) A sink must be located near each toilet.

(ii) A toilet and sink must be provided on each floor where rooms of members who are non-ambulatory or with limited mobility are located.

(iii) There must be at least one (1) toilet, one (1) sink, and one (1) bathtub or shower for every six (6) household occupants, including the provider and family.

(4) **Bedrooms.** A bedroom must:

(A) ~~have~~Have been constructed as such when the home was built or remodeled under permit;

(B) ~~be~~Be provided for each member.

(i)Exception to allow members to share a bedroom may be made by DDS area residential program manager, when DDS determines sharing a bedroom is in the best interest of the member. ~~Minor members must not share bedrooms with adults.~~

(ii) A member must not share a bedroom with more than one (1) other person;

(iii) Minor members must not share bedrooms with adults.

(C) ~~have~~Have a minimum of ~~80~~eighty (80) square feet of usable floor space for each member or ~~120~~one-hundred and twenty (120) square feet for two (2) members and two (2) means of egress. The provider, family members, or other occupants of the home must not sleep in areas designated as common use living areas, nor share bedrooms with members;

(D) ~~be~~Be finished with walls or partitions of standard construction that go from floor to ceiling;

(E) ~~be~~Be adequately ventilated, heated, cooled, and lighted;

(F) ~~include~~Include an individual bed for each member consisting of a frame, box spring, and mattress at least ~~36~~thirty-six (36) inches wide, unless a specialized bed is required to meet identified needs. Cots, rollaways, couches, futons, and folding beds must not be used for members.

(i) Each bed must have clean bedding in good condition consisting of a mattress pad, bedspread, two (2) sheets, pillow, pillowcase, and blankets adequate for the weather.

(ii) Sheets and pillowcases must be laundered at least weekly or more often if necessary.

(iii) Waterproof mattress covers must be used for members who are incontinent;

(G) ~~have~~Have sufficient space for each member's clothing and personal effects, including hygiene and grooming supplies.

(i) Members must be allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space.

(ii) The provider assists the member in furnishing and decorating the member's bedroom.

(iii) Window coverings must be in good condition and allow privacy for members;

(H) ~~be~~Be on ground level for members with impaired mobility or who are non-ambulatory; and

(I) ~~be~~Be in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with ~~a call bell or intercom.~~an alert system.

(5) **Food.**

(A) Adequate storage must be available to maintain food at the proper temperature, including a properly working refrigerator. Food storage must be such that food is protected from dirt and contamination and maintained at proper temperatures to prevent spoilage.

(B) Utensils, dishes, glassware, and food supplies must not be stored in bedrooms, bathrooms, or living areas.

(C) Utensils, dishes, and glassware must be washed and stored to prevent contamination.

(D) Food storage and preparation areas and equipment must be clean, free of offensive odors, and in good repair.

(6) **Phone.**

(A) A working phone must be provided in the home that is available and accessible for the member's use for incoming and outgoing calls.

(B) Phone numbers to the home and providers must be kept current and provided to DDS and, when applicable, the provider agency.

(7) **Safety.**

(A) Buildings must meet all applicable state building, mechanical, and housing codes.

(B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and in good repair.

(i) Protective glass screens or metal mesh curtains attached at top and bottom are required on fireplaces.

(ii) Unvented portable oil, gas, or kerosene heaters are prohibited.

(C) Extension cord wiring must not be used in place of permanent wiring.

(D) Hardware for all exit and interior doors must have an obvious method of operation that cannot be locked against egress.

(8) **Emergencies.**

(A) Working smoke detectors must be provided in each bedroom, adjacent hallways, and in two (2) story homes at the top of each stairway. Alarms must be equipped with a device that warns of low battery condition, when battery operated.

(B) At least one (1) working fire extinguisher must be in a readily accessible location.

(C) A working flashlight must be available for emergency lighting on each floor of the home.

(D) The provider:

(i) ~~maintains~~Mainstays a working carbon monoxide detector in the home;

(ii) ~~maintains~~Mainstays a written evacuation plan for the home and conducts training for evacuation with the member;

(iii) ~~conducts~~Conducts fire drills quarterly and severe weather drills twice per year;

(iv) ~~makes~~Makes fire and severe weather drill documentation available for review by DDS;

(v) ~~has~~Has a written back-up plan for temporary housing in the event of an emergency; and

(vi) ~~is~~Is responsible to re-establish a residence, if the home becomes uninhabitable.

(E) A first aid kit must be available in the home.

(F) The address of the home must be clearly visible from the street.

(9) **Special hazards.**

(A) Firearms and other dangerous weapons must be stored in a locked permanent enclosure. Ammunition must be stored in a separate locked location. Providers are prohibited from

assisting members to obtain, possess, or use dangerous or deadly weapons, per OAC 340:100-5-22.1.

(B) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers.

(C) Cleaning supplies, medical sharps containers, poisons, and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, food preparation areas, dining areas, and medications.

(D) Illegal substances are not permitted on the premises.

(10) **Vehicles.**

(A) All vehicles used to transport members must meet local and state requirements for accessibility and safe transit, licensing, inspection, insurance, and capacity.

(B) Drivers of vehicles must have valid and appropriate driver licenses.

(11) **Medication.** Medication for the member is stored, per OAC 340:100-5-32.

(e) **Evaluating the applicant and home.** The initial home profile evaluation includes, but is not limited to:

(1) ~~evaluating~~Evaluating the applicant's:

(A) ~~interest~~Interest and motivation;

(B) ~~life~~Life skills;

(C) ~~children;~~Children;

(D) ~~methods~~Methods of behavior support and discipline;

(E) ~~marital~~Marital status, background, and household composition;

(F) ~~income~~Income and money management; and

(G) ~~teamwork~~Teamwork and supervision, back-up plan, and use of relief; and

(2) ~~assessment~~Assessment and recommendation. DDS staff:

(A) ~~evaluates~~Evaluates the ability of the applicant to provide services;

(B) ~~assesses~~Assesses the overall compatibility of the applicant and the service recipient, ensuring the lifestyles and personalities of each are compatible for the shared living arrangement. The applicant must:

(i) ~~express~~Express a long term commitment to the service member unless the applicant will only be providing respite services;

(ii) ~~demonstrate~~Demonstrate the skills to meet the individual needs of the member;

(iii) ~~express~~Express an understanding of the commitment required as a provider of services;

(iv) ~~express~~Express an understanding of the impact the arrangement will have on personal and family life;

(v) ~~demonstrate~~Demonstrate the ability to establish and maintain positive relationships, especially during stressful situations; and

(vi) ~~demonstrates~~Demonstrates the ability to work collaboratively and cooperatively with others in a team process;

(C) ~~approves~~Approves only applicants who can fulfill the expectations of the role of service provider;
(D) ~~when~~When the applicant does not meet standards, per OAC 317:40-5-40, ensures the final recommendation includes:
(i) ~~a~~A basis for the denial decision; and
(ii) ~~an~~An effective date for determining the applicant does not meet standards. Reasons for denying a request to be a provider may include, but are not limited to:
(I) ~~a~~A lack of stable, adequate income to meet the applicant's own or total family needs or poor management of the available income;
(II) ~~a~~A physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;
(III) ~~the~~The age, health, or any other condition of the applicant that impedes the applicant's ability to provide appropriate care for a member;
(IV) ~~relationships~~Relationships in the applicant's household that are unstable and unsatisfactory;
(V) ~~the~~The mental health of the applicant or other family or household member that impedes the applicant's ability to provide appropriate care for a member;
(VI) ~~references~~References who are guarded or have reservations in recommending the applicant;
(VII) ~~the~~The applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;
(VIII) ~~the~~The home is determined unsuitable for the member requiring placement;
(IX) ~~confirmed~~Confirmed abuse, neglect, or exploitation of any person;
(X) ~~breach~~Breach of confidentiality;
(XI) ~~involvement~~Involvement of the applicant or provider involvement in criminal activity or criminal activity in the home;
(XII) ~~failure~~Failures to complete training, per OAC 340:100-3-38;
(XIII) ~~failure~~Failures of the home to meet standards per subsection (d) of this Section; and
(XIV) ~~failure~~Failures to follow applicable ~~DHS~~OKDHS or Oklahoma Health Care Authority ~~(OHCA) rules;~~(OHCA) rules;
(E) ~~notifies~~Notifies the applicant in writing of the final approval or denial of the home profile;
(F) ~~when~~When an application is canceled or withdrawn prior to completion of the home profile, completes a final written assessment that includes the:
(i) ~~reason~~Reason the application was canceled or withdrawn; ~~and~~
(ii) DDS staff's impression of the applicant based on information obtained; and

(iii) ~~effective~~Effective date of cancellation or withdrawal. Written notice is sent to the applicant to confirm cancellation or withdrawal of the application, and a copy is included in local and State Office records.

(f) **Frequency of evaluation.** Home profile evaluations are completed for initial approval or denial of an applicant. After an initial approval, a home profile review is conducted annually and as needed for compliance and continued approval. DDS area residential services staff conduct at least biannual home visits to specialized foster care providers. The annual home profile review is a comprehensive review of the living arrangement, the provider's continued ability to meet standards, the needs of the member and the home to ensure ongoing compliance with home standards. A home profile review is conducted when a provider notifies DDS of his or her intent to move to a new residence. DDS staff ~~asses~~assesses the home to ensure the new home meets home standards and is suitable to meet the member's needs. The annual home profile review;

(1) ~~includes~~Includes information specifically related to the provider's home and is documented ~~on DHS Form 06AC024E, Annual Review;~~as an annual review;

(2) ~~includes form 06AC010E, Medical Examination Report,~~Includes a medical examination report completed a minimum of every three (3) years following the initial approval, unless medical circumstances warrant more frequent completion;

(3) ~~includes~~Includes information from the DDS case manager, the provider of agency companion or SFC services, the Child Welfare specialist, Adult Protective Services, and Office of Client Advocacy staff, and the provider agency program coordinator when applicable.

(4) ~~includes~~Includes information from the service member indicating satisfaction with service and a desire to continue the arrangement;

(5) ~~addresses~~Includes areas of service where improvement is needed;

(6) ~~includes~~Includes areas of service where progress was noted or were of significant benefit to the member;

(7) ~~ensures~~Ensures background investigation, per OAC 317:40-5-40(b), is repeated every year, except for the OSBI and FBI national criminal history search;

(8) ~~ensures~~Ensures the FBI national criminal history search, per OAC 317:40-5-40(b)(4)(A)(ii), is repeated every five (5) years;

(9) ~~includes~~Ensures written notification to providers and agencies, when applicable, of the continued approval of the provider.

(10) ~~includes~~Includes written notification to providers and agencies, when the provider or agency fails to comply with the home standards, per OAC 317:40-5-40 including deadlines for correction of the identified standards~~; and includes copies of DHS Forms 06AC024E and, when applicable, 06AC010E, in local and State Office records~~.

(g) Reasons a home profile review may be denied include, but are not limited to:

(1) ~~lack~~Lack of stable, adequate income to meet the provider's own or total family needs or poor management of available income;
(2) ~~a~~A physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;
(3) ~~the~~The age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;
(4) ~~relationships~~Relationships in the provider's household that are unstable and unsatisfactory;
(5) ~~the~~The mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;
(6) ~~the~~The provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;
(7) ~~the~~The home is determined unsuitable for the member;
(8) ~~failure~~Failure of the provider to complete tasks related to problem resolution, as agreed, per OAC 340:100-3-27;
(9) ~~failure~~Failure of the provider to complete a plan of action, as agreed, per OAC 317:40-5-63;
(10) ~~confirmed~~Confirmed abuse, neglect, or exploitation of any person;
(11) ~~breach~~Breach of confidentiality;
(12) ~~involvement~~Involvement of the applicant or provider involvement in the criminal activity or criminal activity in the home;
(13) ~~failure~~Failure to provide for the care and well-being of the service member;
(14) ~~failure~~Failure or continued failure to implement the individual Plan, per OAC 340:100-5-50 through 100-5-58;
(15) ~~failure~~Failure to complete and maintain training, per OAC 340:100-3-38;
(16) ~~failure~~Failure to report changes in the household;
(17) ~~failure~~Failure to meet standards of the home per subsection (d) of this Section;
(18) ~~failure~~Failure or continued failure to follow applicable ~~DHS~~OKDHS or OHCA rules;
(19) ~~decline~~Decline of the provider's health to the point he or she can no longer meet the needs of the service member;
(20) ~~employment~~Employment by the provider without prior approval of the DDS area programs manager for residential services; or
(21) ~~domestic~~Domestic disputes that cause emotional distress to the member.

(h) **Termination of placement.** When an existing placement is terminated for any reason:
(1) ~~the~~The Team meets to develop an orderly transition plan; and
(2) DDS staff ensures the property of the member and state is removed promptly and appropriately by the member or his or her designee.

PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology (AT) devices and services

(a) **Applicability.** ~~The rules in this~~This Section ~~apply~~applies to AT services and devices authorized by~~ the~~ Oklahoma Department of Human Services ~~(DHS)~~OKDHS Developmental Disabilities Services (DDS) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

(A) ~~visual~~Visual alarms;

(B) ~~telecommunication~~Telecommunication devices (TDDS);

(C) ~~telephone~~Telephone amplifying devices;

(D) ~~other devices~~Devices for the protection of health and safety of members who are deaf or hard of hearing;

(E) ~~tape~~Tape recorders;

(F) ~~talking~~Talking calculators;

(G) ~~specialized~~Specialized lamps;

(H) ~~magnifiers;~~Magnifiers;

(I) ~~braille~~Braille writers;

(J) ~~braille~~Braille paper;

(K) ~~talking~~Talking computerized devices;

(L) ~~other~~ devices for the protection of health and safety of members who are blind or visually impaired;

(M) ~~augmentative~~Augmentative and alternative communication devices including language board and electronic communication~~,~~ devices;

(N) ~~competence based~~Competence-based cause and effect systems, such as switches;

(O) ~~mobility~~Mobility and positioning devices including:

(i) ~~wheelchairs;~~Wheelchairs;

(ii) ~~travel~~Travel chairs;

(iii) ~~walkers;~~Walkers;

(iv) ~~positioning~~Positioning systems;

(v) ~~ramps;~~Ramps;

(vi) ~~seating~~Seating systems;

(vii) ~~standers;~~Standers;

(viii) ~~lifts;~~Lifts;

(ix) ~~bathing~~Bathing equipment;

(x) ~~specialized~~Specialized beds; and

(xi) ~~specialized~~Specialized chairs;

(P) ~~orthotic~~Orthotic and prosthetic devices, including:

(i) ~~braces;~~Braces

(ii) ~~prescribed~~Precribed modified shoes; and

(iii) ~~splints;~~Splints;

(Q) ~~environmental~~Environmental controls or devices;

(R) ~~items~~Items necessary for life support, and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare~~; and~~ (Medicaid); and

(S) ~~devices for the protection of~~Devices to protect the member's health and safety~~.~~ can include, but are not limited to:

(i) Motion sensors;

(ii) Smoke and carbon monoxide alarms;

(iii) Bed and/or chair sensors;

(iv) Door and window sensors;

(v) Pressure sensors in mats on the floor;

(vi) Stove guards or oven shut off systems;

(vii) Live web-based remote supports;

(viii) Cameras;

(ix) Automated medication dispenser systems;

(x) Software to operate accessories included for environmental control;

(xi) Software applications;

(xii) Personal Emergency Response Systems (PERS) or Mobile;

(xiii) Emergency Response Systems (MER);

(xiv) Global positioning system (GPS) monitoring devices;

(xv) Radio frequency identification;

(xvi) Computers and tablets;

(xvii) Any other device approved by the Developmental; and

(xviii) Disabilities Services (DDS) director or designee.

(2) AT services include:

(A) ~~sign~~Sign language interpreter services for members who are deaf;

(B) ~~reader~~Reader services;

(C) ~~auxiliary~~Auxillary aids;

(D) ~~training~~Training the member and provider in the use and maintenance of equipment and auxiliary aids;

(E) ~~repair~~Repair of AT devices; and

(F) ~~evaluation~~Evaluation of the member's AT needs.

(3) AT devices and services must be included in the member's Individual Plan (IP), prescribed by a physician with a SoonerCare (Medicaid) contract, and arrangements for this HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a Durable Medical Equipment (DME) contract with the Oklahoma Health Care Authority (OHCA).

(5) AT devices and services are authorized in accordance with requirements of The Oklahoma Central Purchasing Act, other applicable statutory provisions, Oklahoma Administrative Code ~~OAC~~OAC 580:15 and ~~DHS approved~~OKDHS-approved purchasing procedures.

(6) AT services are provided by an appropriate professional services provider with a current HCBS contract with OHCA and current, unrestricted licensure and certification with their professional board, when applicable.

(7) AT devices or services may be authorized when the device or service:

(A) ~~has~~Has no utility apart from the needs of the person receiving services;

(B) ~~is~~Is not otherwise available through SoonerCare~~,~~ (Medicaid) an AT retrieval program, the Oklahoma Department of Rehabilitative Services, or any other third party or known community resource;

(C) ~~has~~Has no less expensive equivalent that meets the member's needs;

(D) ~~is~~Is not solely for family or staff convenience or preference;

(E) ~~is~~Is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;

(F) ~~is~~Is of direct medical or remedial benefit to the member;

(G) enables the member to maintain, increase, or improve functional capabilities;

(H) ~~is~~Is supported by objective documentation included in a professional assessment, except as specified, per OAC 317:40-5-100;

(I) ~~is~~Is within the scope of assistive technology, per OAC 317:40-5-100;

(J) ~~is~~Is the most appropriate and cost effective bid, ~~if~~when applicable; and

(K) ~~exceeds~~Exceeds a cost of ~~$50.~~seventy-five dollars ($75) AT devices or services with a cost of ~~$50~~seventy-five dollars ($75) or less, are not authorized through DDS HCBS Waivers.

(8) The homeowner must sign a written agreement for any AT equipment that attaches to the home or property.

(c) **Assessments.** Assessments for AT devices or services are performed by a licensed, professional service provider and reviewed by other providers whose services may be affected by the ~~type of~~ device selected. A licensed, professional service provider must:

(1) ~~determine whether~~Determine if the member's identified outcome can be accomplished through the creative use of other resources, such as:

(A) ~~household~~Household items or toys;

(B) ~~equipment~~Equipment loan programs;

(C) ~~low-technology~~Low-technology devices or other less intrusive options; or

(D) ~~a~~A similar, more cost-effective device;

(2) ~~recommend~~Recommend the most appropriate AT based on the member's:

(A) ~~present~~Present and future needs, especially for members with degenerative conditions;

(B) ~~history~~History of use of similar AT, and his or her current ability to use the device~~ currently and for at least the foreseeable future no less than 5~~and for the next five (5) years; and

(C) ~~outcomes;~~Outcomes;

(3) ~~complete~~Complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:

(A) ~~a review of the device considered;~~A dice review;

(B) ~~availability~~Availability of the device rental with discussion of advantages and disadvantages;

(C) ~~how~~How frequently~~,~~ and in what situations the device will be used in daily activities and routines;

(D) ~~how~~How the member and caregiver(s) will be trained to safely use the AT device; and

(E) ~~the~~The features and specifications of the device necessary for the member, including rationale for why other alternatives are not available to meet the member's needs; and

(4) Upon DDS staff's request, provide a current, unedited ~~videotape or pictures~~video or photographs of the member using the device, including ~~the~~recorded trial time frames~~ of the trials recorded, upon request by DDS staff~~.

(d) **~~Authorization of repairs, or replacement of parts.~~Repairs and placement part authorization.** ~~Repairs to AT devices, or replacement of device parts,~~ AT device repairs or parts replacements, do not require a professional assessment or recommendation. DDS~~ area office~~ resource development staff with assistive technology experience may authorize repairs and replacement of parts for previously recommended ~~assistive technology.~~AT.

(e) **~~Retrievals of assistive technology devices.~~AT device retrieval.** When~~ devices are no longer needed by~~ a member~~,~~ no longer needs an AT device, ~~DHS~~OKDHS DDS staff may retrieve the device.

(f) **Team decision-making process.** The member's Team reviews the licensed professional's assessment and decision-making review. The Team ensures the recommended AT:

(1) ~~is~~Is needed by the member to achieve a specific, identified functional outcome.

(A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

(B) Functional outcomes must be reasonable and necessary given a member's age, diagnosis, and abilities;

(2) ~~allows~~Allows the member receiving services to:

(A) ~~improve~~Improve or maintain health and safety;

(B) ~~participate~~Participate in community life;

(C) ~~express~~Express choices; or

(D) ~~participate~~Participate in vocational training or employment;

(3) ~~will~~Will be used frequently or in a variety of situations;

(4) ~~will~~Will easily fit into the member's lifestyle and work place;

(5) ~~is~~Is specific to the member's unique needs; and

(6) ~~is~~Is not authorized solely for family or staff convenience.

(g) **Requirements and standards for AT devices and service providers.**

(1) Providers guarantee devices, work, and materials for one (1) calendar year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluates the need for AT, and individually customizes AT devices ~~as needed~~.

(h) **Services not covered through AT devices and services.** ~~Assistive technology~~AT devices and services do not include:

(1) ~~trampolines;~~Trampolines;

(2) ~~hot~~Hot tubs;

(3) ~~bean~~Bean bag chairs;

(4) ~~recliners~~Recliners with lift capabilities;

(5) ~~computers~~Computers, except as adapted for individual needs as a primary means of oral communication, and approved, per OAC 317:40-5-100;

(6) ~~massage~~Massage tables;

(7) ~~educational~~Educational games and toys; or

(8) ~~generators.~~Generators.

(i) **~~Approval or denial of AT.~~AT approval or denial.** DDS approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or ~~lease/purchase~~lease or purchase of the AT is determined, per OAC 317:40-5-100.

(1) The DDS case manager sends the AT request to designated DDS ~~area office~~AT-experienced resource development staff ~~with AT experience~~. The request must include:

(A) ~~the~~The licensed professional's assessment and decision making review;

(B) ~~a~~A copy of the Plan of Care (POC);

(C) ~~documentation of~~Documentaion of the current Team consensus, including consideration of issues, per OAC 317:40-5-100; and

(D) ~~all~~All additional documentation to support the ~~need for the~~ AT device or service~~.~~ need.

(2) The designated ~~area office~~AT-experienced resource development staff~~, with AT experience,~~ approves or denies the AT request when the device costs less than ~~$2500.~~$5000.

(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost of ~~$2500~~$5000 or more.

(4) Authorization for purchase or a written denial is provided within ~~10~~ten (10) business days of receipt of a complete request~~.~~;

(A) If the AT is approved, a letter of authorization is issued~~.~~;

(B) If additional documentation is required by the ~~area office~~AT-experienced resource development staff ~~with AT experience~~, to authorize the recommended AT, the request packet is returned to the case manager for completion~~.~~;

(C) When necessary, the case manager contacts the licensed professional to request the additional documentation~~.~~; and

(D) The authorization of ~~a $2,500~~an AT device of $5000 or more ~~AT~~ is completed per (2) of this subsection, ~~except~~

~~that~~and the ~~area office~~AT-experienced resource development staff with ~~AT experience~~:

(i) ~~solicits three bids for the AT;~~Solicits three (3) AT bids;

(ii) ~~submits~~Submits the AT request, bids, and other relevant information to the ~~DDS~~ State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and

(iii) ~~the~~The State Office DDS AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation ~~for the AT~~.

(j) **~~Approval of vehicle~~Vehicle approval adaptations.** Vehicle adaptations are assessed and approved, per OAC 317:40-5-100. In addition, the requirements in (1) through (3) of this subsection must be met.

(1) The vehicle ~~to be adapted~~ must be owned or in the process of being purchased by the member receiving services or his or her family~~.~~ in order to be adapted.

(2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to one vehicle in a ~~10-calendar~~ten (10) year period per member. Authorization for more than one vehicle adaptation in a ~~10-year~~ten (10) year period must be approved by the DDS ~~division administrator~~director or designee.

(k) **~~Denial.~~AT denial.** Procedures for denial of an AT device or service are described in (1) through (3) of this subsection.

(1) The person denying the AT request provides a written denial to the case manager citing the reason for denial, per OAC 317:40-5-100.

(2) The case manager sends ~~DHS FORM~~OKDHS Form 06MP004E, ~~the~~ Notice of Action, to the member and his or her family or guardian.

(3) ~~Denial of AT services~~AT service denials may be appealed through the ~~DHS~~OKDHS hearing process, per OAC 340:2-5.

(l) **~~Return of an~~ AT device~~.~~ returns.** When, during a trial use period or rental of a device, the therapist or Team including the licensed professional ~~when available,~~ who recommended the AT~~,~~and, when available, determines the device is not appropriate, the licensed professional sends a brief report describing the ~~reason(s) for the~~ change of device recommendation to the DDS case manager. The DDS case manager forwards the report to the designated ~~area office~~ resource development staff, who arranges for the ~~return of the~~ equipment return to the vendor or manufacturer.

(m) **~~Rental of AT devices.~~AT device rental.** AT devices are rented when the licensed professional or ~~area office~~AT-experienced resource development staff ~~with AT experience~~ determines rental of the device is more cost effective than purchasing the device or the

licensed professional recommends a trial period to determine if the device meets the member's needs.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) ~~Area office~~AT-experienced resource development staff~~ with AT experience~~ monitor use of equipment during the rental agreement for:

(A) ~~cost effectiveness of the rental time frames;~~Rental time frame cost effectiveness;

(B) ~~conditions of renewal; and~~renewal conditions; and

(C) ~~the~~The Team's, including the licensed ~~professional,~~professional's re-evaluation of the member's need for the device, per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device ~~whenever such~~when the option is available from the manufacturer or vendor.

(4) When a device is rented for a ~~trial use~~trial-use period, the Team~~,~~ including the licensed professional, decides within ~~90 calendar~~ninety (90) calendar days whether the device:

(A) ~~the equipment meets~~Meets the member's needs; and

(B) ~~to purchase the equipment or return it.~~Should be purchased or returned.

(n) **~~Assistive Technology Committee.~~AT committee.** The AT committee reviews equipment requests when deemed necessary by the ~~DHS~~OKDHS DDS State Office AT programs manager~~ for AT~~.

(1) The AT committee is comprised of:

(A) DDS professional staff members of the appropriate therapy;

(B) DDS~~ AT~~ State Office AT programs manager;

(C) ~~the~~The DDS area ~~manager~~field administrator or designee; and

(D) ~~an~~An AT expert, not employed by ~~DHS.~~OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria provided in this Section. Any endorsement or denial includes a written rationale for the decision and, ~~if~~when necessary, an alternative solution, directed to the case manager within ~~20~~twenty (20) business days of the receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified, per OAC 317:40-5-100.

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-152. Group home services for persons with an intellectual disability or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to ~~24-hour~~twenty-four (24) hours per day supervision, supportive assistance, and training in daily living

skills to persons who are eligible and ~~18~~eighteen (18) years of age or older. Upon approval of the Oklahoma Department of Human Services ~~DHS~~OKDHS Developmental Disabilities Services ~~DDS~~(DDS) director or designee, persons younger than ~~18~~eighteen (18) years of age may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by ~~DHS~~OKDHS per Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may only be approved by the DDS director or designee:

(A) ~~for~~For a resident of a group home to resolve a temporary emergency when no other resolution exists; or

(B) ~~for~~For a resident of a community living group home when the resident's needs are so extensive that additional supports are needed for identified specific activities; and

(C) ~~weekly~~Weekly average of ~~56~~fifty-six (56) hours of direct contact staff must be provided to the resident before HTS services may be approved.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDS Home and Community-Based Services (HCBS) for persons with an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide DDS group home services.

(2) Group home staff must:

(A) ~~complete~~Complete the ~~DHS~~OKDHS DDS-sanctioned training curriculum, per OAC 340:100-3-38; and

(B) ~~fulfill~~Fulfill requirements for pre-employment screening, per ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) ~~meet~~Meet all applicable requirements of OAC 340:100; and

(B) ~~are~~Are provided in accordance with each member's Individual Plan (IP) developed, per OAC 340:100-5-50 through 340:100-5-58.

(i) Health care services are secured for each member, per OAC 340:100-5-26.

(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

(A) ~~follow~~Follow protective intervention practices, per OAC 340:100-5-57 and 340:100-5-58;

(B) ~~in~~In addition to the documentation required, per OAC 340:100-3-40, must maintain:

(i) ~~staff~~Staff time sheets that document the hours each staff was present and on duty in the group home; and

(ii) ~~documentation~~Documentation of each member's presence or absence on the daily attendance form provided by DDS; and

(C) ~~ensure~~Ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services, per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(d) **Coverage limitations.** Group home services are provided up to ~~366~~three-hundrend and sixty-six (366) days per year.

(e) **Types of group home services.** Three (3) types of group home services are provided through HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than ~~12~~twelve (12) members, per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than ~~12~~twelve (12) members.

(A) Members who receive community living home services:

(i) ~~have~~Have needs that cannot be met in a less structured setting; and

(ii) ~~require~~Require regular, frequent, and sometimes constant assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting; or

(iii) ~~require~~Require supervision and training in appropriate social and interactive skills, due to on-going behavioral issues to remain included in the community.

(B) Services offered in a community living home include:

(i) ~~24-hour~~Twenty-four (24) hour awake supervision when a member's IP indicates it is necessary; and

(ii) ~~program~~Program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(C) Services may be approved for individuals in a traditional group home at the community living service rate when the member has had a change in health status or behavior and meets the requirements to receive community living home services. ~~Requests to receive community living home services are sent to the DDS Community Services Residential Unit.~~

(3) **Alternative group homes.** Alternative group homes serve no more than four (4) members who have evidence of behavioral or emotional challenges in addition to an intellectual disability and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria, per ~~in~~ OAC 340:100-5-22.6.

(B) A determination must be made by the DDS ~~Community Services Unit~~director or designee that alternative group home services are appropriate.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-11. Stabilization Services

Stabilization Services are ongoing support services needed to maintain a member in an integrated competitive employment site. Stabilization Services are provided for up to two (2) years per job. Stabilization Services continue until the next Plan of Care following the end of two (2) years of Stabilization Services.

(1) Stabilization Services are provided when the job coach intervention time required at the job site is ~~20%~~twenty percent (20%) or less of the member's total work hours for four (4) consecutive weeks or when the member moved from Department of Rehabilitation Services (DRS) services.

(A) If, after the member moves to Stabilization~~,~~ Services the Team determines that support is needed above ~~20%~~twenty percent (20%) for longer than two (2) weeks, the Team may revise the member's Plan of Care to reflect the need for Job Coaching Services.

(B) A member receiving services from DRS moves to services funded by ~~DDSD~~DDS upon completion of the Job Stabilization milestone. The employment provider agency submits the request for transfer of funding during the Job Stabilization milestone as described in the DRS Supported Employment contract.

(2) Stabilization Services must:

(A) ~~identify~~Identify the supports needed, including development of natural supports;

(B) ~~specify,~~Specify, in a measurable manner, the services ~~to be~~ provided.

(3) Reimbursement for Stabilization Services is based upon the number of hours the member is employed at a rate of minimum wage or above.

(4) ~~If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.~~ Stabilization Services may be authorized through remote supports per a Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Team has an approved remote supports risk assessment.

(5) If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.

I.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION
317:30-3-5 [AMENDED]
(REFERENCE APA WF # 20-29)

317:30-3-5. Assignment and cost sharing

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

(1) **"Fee-for-service contract"** means the provider agreement specified in Oklahoma Administrative Code (OAC) 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority (OHCA) and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(b) **Assignment in fee-for-service.** Oklahoma's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee-for-service contract and also executes a contract with a provider in

the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the OHCA shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost sharing/co-payment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee-for-service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age twenty-one (21). Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, including prenatal

vitamins.

(D) Smoking and tobacco cessation counseling and products.

(E) Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians;

(ii) Advanced practice registered nurses;

(iii) Physician assistants;

(iv) Optometrists;

(v) Home health agencies;

(vi) Certified registered nurse anesthetists;

(vii) Anesthesiologist assistants;

(viii) Durable medical equipment providers; and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

(5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

J.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 10. BARIATRIC SURGERY
317:30-5-137 [AMENDED]
317:30-5-137.1 [REVOKED]
317:30-5-137.2 [REVOKED]
317:30-5-140 [AMENDED]
317:30-5-141 [REVOKED]
(REFERENCE APA WF # 20-33)

317:30-5-137. ~~Eligible providers to perform bariatric surgery~~Bariatric surgery

~~The Oklahoma Health Care Authority (OHCA) covers bariatric surgery under certain conditions as defined in this section. Bariatric surgery is not covered for the treatment of obesity alone. To be eligible for reimbursement, bariatric surgery providers must be certified by the American College of Surgeons (ACS) as a Level I Bariatric Surgery Center or certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) or the surgeon and facility are currently participating in a bariatric surgery quality assurance program and a clinical outcomes assessment review. All qualifications must be met and approved by the OHCA. Bariatric surgery facilities and their providers must be contracted with OHCA.~~(a) **Bariatric surgery.** Gastric bypass and other types of weight-loss surgery, known as bariatric surgery, makes surgical changes to the stomach and digestive system, limits food intake and nutrient absorption, which leads to weight loss.

(b) **Eligible providers.** Bariatric surgery providers must be:

(1) Certified by the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) as a Comprehensive Bariatric Surgery Center; or

(2) Currently participating in a comprehensive multidisciplinary bariatric surgery quality assurance program and a clinical outcomes assessment review as a pathway to accreditation; and

(3) Completed a fellowship training in bariatric surgery or be a fellow of the American Society of Metabolic and Bariatric Surgery (ASMBS) or a MBSAQIP verified surgeon; and

(4) Contracted with the Oklahoma Health Care Authority (OHCA); and

(5) Have a demonstrated record of quality assurance.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f). Documentation requirements include, but are not limited to:

(1) Documents sufficient to show that member is between the ages of fifteen (15) to sixty-five (65);

(2) Psychosocial evaluation;
(2) Independent medical evaluation by a health care professional with dedicated expertise in the care of bariatric surgery patients;
(3) Surgical evaluation by an OHCA-contracted surgeon who is credentialed to perform bariatric surgery;
(4) Record on participation in a nutrition and lifestyle modification program under the supervision of an OHCA contracted medical provider; and
(5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Non-covered services.**
(1) Procedures considered experimental or investigational are not covered.
(2) The OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member, provider, or bariatric program is not in compliance with any of the requirements.

(e) **Reimbursement.**
(1) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee.
(2) To be eligible for reimbursement, bariatric surgery providers must meet the requirements listed in (b) (1) through (5) of this Section.
(3) Payment shall be made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services and in accordance with the Oklahoma Medicaid State Plan.

317:30-5-137.1. Member candidacy [REVOKED]

~~Documentation must be submitted to the OHCA prior authorization unit prior to beginning any treatment program to ensure all requirements are met and the member is an appropriate candidate for bariatric surgery. This is the first of two prior authorizations required to approve a member for bariatric surgery. To be considered, members must meet the following candidacy criteria:~~
~~(1) be between 18 and 65 years of age;~~
~~(2) have body mass index (BMI) of 35 or greater;~~
~~(3) be diagnosed with one of the following:~~
~~(A) diabetes mellitus;~~
~~(B) degenerative joint disease of a major weight bearing joint(s). The member must be a candidate for joint replacement surgery when optimal weight loss is achieved; or~~
~~(C) a rare co-morbid condition in which there is medical evidence that bariatric surgery is medically necessary to treat such a condition and that the benefits of bariatric surgery outweigh the risk of surgical mortality.~~
~~(4) have presence of obesity that has persisted for at least 5 years;~~
~~(5) have attempted weight loss in the past without successful long term weight reduction, which must be documented by a physician;~~
~~(6) have absence of other medical conditions that would increase~~

~~the member's risk of surgical mortality or morbidity; and~~
~~(7) the member is not pregnant or planning to become pregnant in the next two years.~~

317:30-5-137.2. General coverage [REVOKED]

~~(a) After receiving member candidacy prior authorization from OHCA and the determination that member candidacy requirements are met (see OAC 317:30-5-137.1), the primary care provider coordinates a pre-operative assessment and weight loss process to include:~~
~~(1) a comprehensive psychosocial evaluation including:~~
~~(A) evaluation for substance abuse;~~
~~(B) evaluation for psychiatric illness which would preclude the member from participating in pre-surgical weight loss and evaluation program or successfully adjusting to the post surgical lifestyle changes;~~
~~(C) if applicable, documentation that the member has been successfully treated for a psychiatric illness and has been stabilized for at least six months; and~~
~~(D) if applicable, documentation that the member has been rehabilitated and is free from drug and/or alcohol for a period of at least one year.~~
~~(2) an independent medical evaluation performed by an internist experienced in bariatric medicine who is contracted with the OHCA to assess the member's operative morbidity and mortality risks.~~
~~(3) a surgical evaluation by an OHCA contracted surgeon who has credentials to perform bariatric surgery.~~
~~(4) participation in a six month weight loss program prior to surgery, under the supervision of an OHCA contracted medical provider. The member must, within 180 days from the initial or member candidacy prior authorization approval, lose at least five percent of member's initial body weight.~~
~~(b) When all requirements have been met, a prior authorization for surgery must be obtained from OHCA. This authorization can not be requested before the initial 180 day weight loss program has been completed.~~
~~(1) If the member does not meet the weight loss requirement in the allotted time the member will not be approved for bariatric surgery.~~
~~(2) The member's provider must restart the prior authorization process if this requirement is not met.~~
~~(c) The bariatric surgery facility or surgeon must, on an annual basis, provide to the OHCA the members statistical data which includes but is not limited to, mortality, hospital readmissions, re-operation, morbidity and average weight loss data.~~
~~(d) OHCA considers surgery to correct complications from bariatric surgery, such as obstruction or stricture, medically necessary.~~
~~(e) OHCA considers repeat bariatric surgery medically necessary for a member whose initial bariatric surgery was medically necessary, and member meets either of the following criteria:~~
~~(1) has not lost more than fifty percent of excess body weight two years following the primary bariatric surgery procedure and~~

~~is in compliance with prescribed nutrition and exercise programs following the procedure; or~~

~~(2) failure due to dilation of the gastric pouch if the initial procedure was successful in inducing weight loss prior to the pouch dilation and the member is in compliance with prescribed nutrition and exercise programs following the initial procedure.~~

~~(f) OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member or provider is not in compliance with any of the requirements.~~

317:30-5-140. Coverage for children

~~(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA Medicaid program. Such services must be prior authorized.~~

~~(b) Federal Medicaid regulations also require the state to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the state determines are not safe and effective or which are considered experimental.~~Bariatric surgery services are currently allowed for members aged fifteen (15) to sixty-five (65), per OAC 317:30-5-137 (c) (1). Exceptions may be granted for member's younger than fifteen (15) if they are proven to be medically necessary and are prior authorized. State and Federal Medicaid law, including, but not limited to, Oklahoma's federally-approved State Medicaid Plan, require the State to make the determination as to whether services are medically necessary and does not allow for reimbursement of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational see OAC 317:30-3-57.1.

317:30-5-141. Reimbursement [REVOKED]

~~Payment is made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services.~~