

Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule changes by the comment due date. Comments can be submitted on the OHCA's [Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: January 15, 2020

The proposed policy changes are Permanent Rules. The proposed policy changes were presented at the November 5, 2019 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on January 9, 2020 and the OHCA Board of Directors on January 22, 2020.

Reference: APA WF # 19-31

SUMMARY:

Nursing Licensure Revisions — The proposed revisions will comply with 59 O.S. § 567.21, which allows Oklahoma to enter into the enhanced Nurse Licensure Compact (eNLC). The eNLC is an agreement between states that allows a nurse's licensure to be portable to other member-states of the Compact. These revisions amend references that narrowly tie a nurse's license to the Oklahoma Board of Nursing and align SoonerCare rules with the eNLC.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; and the Oklahoma Health Care Authority Board; 59 O.S. § 567.21.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Maria Maule
Legal Services

FROM: Vanessa Andrade
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 19-31

A. Brief description of the purpose of the rule:

The proposed rule changes will comply with 59 O.S. § 567.21, which allows Oklahoma to enter into the enhanced Nurse Licensure

Compact (eNLC). The eNLC is an agreement between states that allows a nurse's licensure to be portable to other member-states of the Compact. These revisions amend references that narrowly tie a nurse's license to the Oklahoma Board of Nursing and align SoonerCare rules with the eNLC.

- B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Nursing providers and SoonerCare members will be affected by the proposed rule changes.

- C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit contracted nursing providers with an eNLC multistate license by allowing them to practice in both their home state and other eNLC states, without having to obtain additional licenses. The proposed rule changes will also benefit SoonerCare members by increasing access to care.

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact for the proposed rule changes upon any classes of persons or political subdivisions. There are no fee changes associated with the proposed rule revisions.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes will be budget neutral.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the

rule:

The proposed rule changes will have no economic impact on political subdivisions, nor will the cooperation of any political subdivisions be required for implementation or enforcement of the rule changes.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule changes will have no anticipated adverse effects on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has determined that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule changes.

- I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should have no adverse effect on the public health, safety, and environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on public health, safety, or the environment at this time.

- K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: October 31, 2019
Modified: December 16, 2019

RULE TEXT:

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.3. ~~Staff Credentials~~credentials

(a) ~~Licensed Behavioral Health Professional~~behavioral health professional (LBHPs). LBHPs are defined as ~~follows~~any of the following practitioners:

(1) ~~Allopathic or Osteopathic Physicians~~An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-2.

(2) ~~Practitioners~~A practitioner with a current license to practice in the state in which services are provided, issued by one (1) of the licensing boards within one (1) of the areas of practice listed in (A) through (F). The exemptions from licensure under Title 59 of the Oklahoma Statutes (O.S.), ~~Section (S) 1353(4) (Supp. 2000) and (5), 59 O.S. § 1903(C) and (D) (Supp. 2000), 59 O.S. § 1925.3(B) (Supp. 2000) and (C), and 59 O.S. § 1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services~~outpatient behavioral health services.

(A) ~~Psychology~~;

(B) ~~Social Work~~work (clinical specialty only);

(C) ~~Professional Counselor~~, counselor;

(D) ~~Marriage and Family Therapist~~, family therapist;

(E) ~~Behavioral Practitioner~~, or practitioner; or

(F) ~~Alcohol and Drug Counselor~~drug counselor.

(3) ~~Advanced Practice Nurse (certified in a psychiatric mental health specialty)~~An advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) ~~A Physician Assistant~~physician assistant who is licensed and in good standing in this the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) ~~Licensure Candidates~~candidates. Licensure candidates are

practitioners actively and regularly receiving ~~board approved~~board-approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the ~~licensing boards~~areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

- (1) ~~staff~~Staff the member's case with the candidate;;
- (2) ~~be~~Be personally available, or ensure the availability of an LBHP to the licensure candidate for consultation while they are providing services;;
- (3) ~~agree~~Agree with the current plan for the member,and;
- (4) ~~confirm~~Confirm that the service provided by the candidate was appropriate; and
- (5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) ~~Certified Alcohol and Drug Counselors~~alcohol and drug counselors (CADCs). CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) ~~Multi-Systemic Therapy (MST) Providers~~systemic therapy (MST) provider. ~~Masters~~Master's level therapist who works on a team established by ~~OJA~~the Oklahoma Juvenile Affairs Office (OJA) which may include ~~Bachelor~~bachelor's level staff.

(e) ~~Peer Recovery Support Specialist~~recovery support specialist (PRSS). The ~~Peer Recovery Support Specialist~~PRSS must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

(f) ~~Family Support and Training Provider (FSP)~~. FSPs are defined as follows:

- ~~(1) Have a high school diploma or equivalent;~~
- ~~(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years' experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);~~
- ~~(3) successful completion of ODMHSAS Family Support Training;~~
- ~~(4) pass background checks;~~
- ~~(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and~~
- ~~(6) must function under the general direction of an LBHP, or~~

~~Licensure Candidate or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.~~**Family support and training provider (FSP)**. FSPs must:

- (1) Have a high school diploma or equivalent;
- (2) Be twenty-one (21) years of age and have a successful experience as a family member of a child/adolescent with serious emotional disturbance, or a minimum of have lived experience as the primary caregiver of a child/adolescent who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child/adolescent with Child Welfare/Child Protective Services involvement;
- (3) Successfully complete family support training according to a curriculum approved by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and pass the examination with a score of eighty (80) percent or better;
- (4) Pass Oklahoma State Bureau of Investigation (OSBI) background check;
- (5) Have treatment plans be overseen and approved by a licensed behavioral health professional (LBHP) or licensure candidate; and
- (6) Function under the general direction of an LBHP, licensure candidate or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

(g) ~~**Behavioral Health Aide (BHA)**~~. BHAs are defined as follows:

- ~~(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or~~
- ~~(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and~~
- ~~(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and~~
- ~~(4) must be supervised by a bachelor's level individual with a minimum of two years case management or care coordination experience; and~~
- ~~(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and~~
- ~~(6) must function under the general direction of an LBHP, or Licensure Candidate and/or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.~~**Qualified behavioral health aide (QBHA)**. QBHAs must:

- (1) Have completed sixty (60) hours or equivalent of college credit; or may substitute one (1) year of relevant employment and/or responsibility in the care of children with complex

emotional needs for up to two (2) years of college experience; and

(2) Have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(3) Be supervised by a bachelor's level individual with a minimum of two (2) years case management or care coordination experience; and

(4) Have service plans be overseen and approved by an LBHP or licensure candidate; and

(5) Function under the general direction of an LBHP, or licensure candidate and/or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

(h) **Behavioral Health Case Managerhealth case manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, ~~Licensure Candidate~~licensure candidate, CADC or have and maintain a current certification as a ~~Case Manager~~case manager II (CM II) or ~~Case Manager~~case manager I (CM I) from ODMHSAS. The requirements for obtaining these certifications are as follows:

(1) ~~Certified Behavioral Health Case Manager II (CM II)~~The CM II must meet the requirements in (A), (B), (C) or (D) below:

(A) Possess a ~~Bachelor's or Master's~~bachelor's or master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a ~~Bachelor's or Master's~~bachelor's or master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(B) ~~Possess a current license as a registered nurse in the State of Oklahoma~~Be licensed and in good standing as a registered nurse in the state in which services are provided, with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(C) Possess a ~~Bachelor's or Master's~~bachelor's or master's

degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the ~~US Psychiatric Association~~ ~~(USPRA)~~ USPRA must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(D) Possess a ~~Bachelor's or Master's~~ bachelor's or master's degree in any field and proof of active progression toward obtaining a clinical licensure ~~Master's or Doctoral~~ master's or doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(2) ~~Certified Behavioral Health Case Manager~~ The CM I meets the requirements in either (A) or (B) and (C):

(A) ~~completed 60~~ Completed sixty (60) college credit hours; or

(B) ~~has~~ Possesses a high school diploma with ~~36~~ thirty-six (36) total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(C) ~~completes~~ Completes two (2) days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(3) ~~Wraparound Facilitator Case Manager~~ facilitator case manager is a LBHP, ~~Licensure Candidate~~ licensure candidate or CADC that meets the qualifications for CM II and has the following:

(A) ~~successful~~ Successful completion of the ODMHSAS training for wraparound facilitation within six (6) months of employment; and

(B) ~~participate~~ Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(C) ~~successfully~~ Successfully complete wraparound credentialing process within nine (9) months of beginning process; and

(D) ~~direct~~Direct supervision or immediate access and a minimum of one (1) hour weekly clinical consultation with a ~~Qualified Mental Health Professional~~qualified mental health professional, as required by ODMHSAS.

(4) ~~Intensive Case Manager~~case manager is a LBHP, ~~Licensure Candidate~~licensure candidate, or CADC that meets the provider qualifications of a ~~Case Manager~~CM II and has the following:

(A) A minimum of two (2) years ~~Behavioral Health Case Management~~behavioral health case management experience, crisis diversion experience, and

(B) ~~must~~Must have attended the ODMHSAS six (6) hours ~~Intensive~~intensive case management training.

PART 37. ADVANCED PRACTICE REGISTERED NURSE

317:30-5-375. Eligible providers

~~The Advanced Practice Nurse must be a registered nurse in good standing with the Oklahoma Board of Nursing, and have acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and have obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advanced Practice Nurse services are limited to the scope of their practice as defined in 59 O.S. 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9. Rules regarding Certified Nurse Midwives are referenced in OAC 317:30-5-225. Advanced Practice Nurses who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.~~

(a) The advanced practice registered nurse (APRN) must:

(1) Be licensed and in good standing in the state in which services are provided;

(2) Have completed an accredited graduate level advanced practice registered nursing education program approved by the board of nursing in the state in which services are provided;

and

(3) Possess a current national certification by a national certifying body recognized by the board of nursing in the state in which services are provided.

(b) APRN services are limited to the scope of practice defined in 59 O.S. § 567.3a and corresponding administrative rules at Oklahoma Administrative Code (OAC) 485:10-5-1 through 485:10-16-9. Rules regarding certified nurse midwives are referenced in OAC 317:30-5-225. APRNs who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with

the Oklahoma Health Care Authority.

317:30-5-376. Coverage by category

Payment is made to ~~Advanced Practice Nurse~~advanced practice registered nurses (APRNs) as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN, to ~~children and adolescents under 21~~members under twenty-one (21) years of age, including ~~EPSTD~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services ~~and within the scope of the Oklahoma Health Care Authority medical programs.~~

(A) Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis and Treatment of individuals under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

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

PART 39. SKILLED NURSING SERVICES

317:30-5-390. Home and Community-Based Services ~~Waivers~~waivers for adults with an intellectual disability or certain adults with related conditions

(a) **Introduction to waiver services.** Each Home and Community-Based Services (HCBS) ~~Waiver~~waiver that includes services for adults with an intellectual disability or certain adults with related conditions allows payment for home health care services as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(1) Home health care services are skilled nursing services provided to a member by a registered nurse (RN) or a licensed practical nurse (LPN) that include:

(A) ~~direct~~Direct nursing care;

(B) ~~assessment~~Assessment and documentation of health changes;

(C) ~~documentation~~Documentation of significant observations;

(D) ~~maintenance~~Maintenance of nursing plans of care;

- (E) ~~medication~~Medication administration;
- (F) ~~training~~Training of the member's health care needs;
- (G) ~~preventive~~Preventive and health care procedures; and
- (H) ~~preparing~~Preparing, analyzing, and presenting nursing assessment information regarding the member.

(2) The first ~~36~~thirty-six (36) visits provided by the home health care agency are covered by the Medicaid State Plan.

(b) **Eligible providers.** Skilled nursing services providers must enter into contractual agreements with the Oklahoma Health Care Authority to provide HCBS for adults with an intellectual disability or certain adults with related conditions.

(1) Individual providers must be currently licensed ~~in Oklahoma as a~~ and in good standing in the state in which services are provided as a:

- (A) ~~registered nurse~~RN; or
- (B) ~~licensed practical nurse~~LPN.

(2) Agency providers must:

- (A) ~~have~~Have a current Medicaid HCBS home health care agency contract; or
- (B) ~~be~~Be certified by the Oklahoma State Department of Health as a home health care agency.

317-30-5-391. Coverage for ~~Skilled Nursing Services~~skilled nursing services

(a) All ~~Skilled Nursing Services~~skilled nursing services must be ordered and prescribed by a physician, supported by a nursing plan of care, included in the individual plan as described in ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-5-53 and reflected in the ~~Plan of Care~~plan of care approved in accordance with OAC 340:100-3-33 and ~~OAC~~340:100-3-33.1. For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants and advanced practice registered nurses in accordance with the rules and regulations covering the OHCA's medical care program. Arrangements for waiver ~~Skilled Nursing Services~~skilled nursing services are made through the personal support team with the specific involvement of the assigned Developmental Disabilities Services Division (DDSD) registered nurse (RN). The DDSD RN develops a nursing service support plan subject to review and authorization by the DDSD state nursing director or designee.

(b) ~~Skilled Nursing Services~~nursing services are rendered in such a manner as to provide the service recipient as much autonomy as possible.

(1) ~~Skilled Nursing Services~~nursing services must be flexible and responsive to changes in the service recipient's needs.

(2) Providers are expected to participate in annual personal support team meetings and other team meetings as required.

(3) Appropriate supervision of ~~Skilled Nursing Services~~skilled

nursing services including services provided by licensed practical nurses (LPNs) is provided pursuant to State law and regulatory board requirements.

(4) Individual service providers must be RNs or LPNs currently licensed ~~to practice in the State of Oklahoma~~ and in good standing in the state in which services are provided.

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage ~~Program~~program are:

(1) Case management.

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) ~~initiate~~Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) ~~develop~~Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) ~~initiate~~Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) ~~monitor~~Monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) ~~assists~~Assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) ~~helps~~Helps the member transition from institution to home by updating the person-centered service plan;

(III) ~~prepares~~Prepares services to start on the date the member is discharged from the institution; and

(IV) ~~must~~Must meet ADvantage ~~Program~~program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage

provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

(i) ~~any~~Any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1) (A) that only an ADvantage case manager can perform on behalf of the member, because of skill, training, or authority can perform on behalf of a member; and

(ii) ~~ancillary~~Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

(D) Case management services are prior authorized and billed per ~~fifteen minute (15 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 a 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 area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma Department of Human Services (DHS) Aging Services identified zip codes in Osage County adjacent to the 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.

(2) Respite.

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only 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 services are billed per ~~fifteen-minute~~ ~~(15-minute) units~~ fifteen (15) minute unit of service. Within any ~~one-day (1-day)~~ one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of twenty-eight (28) units [seven (7) hours] provided. The service is provided in the member's home.

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

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

(3) Adult day health (ADH) care.

(A) ADH is furnished on a regularly-scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral services to ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a ~~fifteen-minute~~ ~~(15-minute)~~ fifteen (15) minute unit of service. No more than ~~eight (8) hours, thirty-two (32) units~~ ~~[eight (8) hours]~~ eight (8) hours, [thirty-two (32) units] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a

separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.

(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI), as established by the Food and Nutrition Board of the ~~Institute of Medicine of the National Academy~~ Academies of Sciences, Engineering, and Medicine, is provided to those participants who are in the center for four (4) or more hours per day, and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) Personal-care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage ~~Waiver~~ waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry service is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.

(F) DHS Home and Community-Based Services (HCBS) ~~Waiver~~ waiver settings have qualities defined in ~~federal regulation, per Section (§) 441.301 (c) (4) of Title 42 of Code of Federal Regulations (CFR)~~ Home and Community-Based Services: Waiver Requirements, 42 Code of Federal Regulations, Sec. 441.301 (c) (4) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) ~~seek~~ Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) ~~engage~~ Engage in community life;

(III) ~~control~~ Control personal resources; and

(IV) ~~receive~~ Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS ~~Waiver~~ waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) ~~daily~~Daily activities;

(II) ~~the~~The physical environment; and

(III) ~~with whom to interact~~Social interactions.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 CFR § 441.301(c)(5)(v) include, ADH centers:

(i) in a publicly- or privately-owned facility providing inpatient treatment;

(ii) on the grounds of or adjacent to a public institution; and

(iii) with the effect of isolating individuals from the broader community of individuals not receiving ADVantage ~~Program~~program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 CFR § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, ~~OHCA~~the Oklahoma Health Care Authority (OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) Environmental modifications.

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

(B) All services require prior authorization.

(5) Specialized medical equipment and supplies.

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for

life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan are also included. This service excludes any equipment and/or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered 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, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus ~~thirty (30) percent~~thirty percent (30%). All services must have prior authorization.

(6) Advanced supportive/restorative assistance.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

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

(7) Nursing.

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the ~~Oklahoma Nursing Practice Act~~state's Nurse Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice and in good standing in the state in which services are provided. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute

health condition and may not include services reimbursable under either the Medicaid or Medicare ~~Home Health Program~~ 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 they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage ~~Program~~ program case manager and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage ~~Program~~ program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) ~~member's~~ Member's general health, functional ability, and needs; and/or

(II) ~~adequacy~~ 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 per rules and regulations for the delegation of nursing tasks established by the ~~Oklahoma Board of Nursing~~ board of nursing in the state in which services are provided.

(ii) In addition to assessment/evaluation, the ADvantage ~~Program~~ program case manager may recommend authorization of nursing services to:

(I) ~~prepare a one week (1-week)~~ Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

(II) ~~prepare~~ Prepare 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) ~~monitor~~Monitor 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) ~~provide~~Provide nail care for the member with diabetes or member who has circulatory or neurological compromise; and

(V) ~~provide~~Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the ~~Oklahoma Nursing Practice Act~~nurse's license, including private duty nursing. Nursing services are billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan, but other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units, ~~two (2) hours~~[two (2) hours], per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when 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) Skilled nursing services.

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, LPN, or LVN under the supervision of an RN, licensed to practice and in good standing in the state in which services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized

skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per ~~fifteen minute (15-minute) units~~ fifteen (15) minute unit of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) 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 dietary reference intakes as established by the Food and Nutrition Board of the National ~~Academy of Sciences~~ Academies of Sciences, Engineering and Medicine. Home-delivered 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 (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) Occupational therapy services.

(A) Occupational therapy services are 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 enabling him or her 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 limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) Physical therapy services.

(A) Physical therapy services are those services that maintain or improve 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 the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/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. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed ~~thirty-calendar~~ ~~(30-calendar)~~ thirty (30) calendar days. Any treatment required after the ~~thirty-calendar~~ ~~(30-calendar)~~ thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations

of his or her 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 when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services are authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) Speech and language therapy services.

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/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 the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes ~~Speech Language Pathology Assistants~~speech language pathology assistant services within the limitations of his or her practice, working under the supervision of the licensed ~~Speech and Language Pathologists~~speech and language pathologist. The regimen includes education and training for informal caregivers to assist with, and/or maintain services when appropriate. The ~~Speech and Language Pathologists~~speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) Hospice services.

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life

expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a ~~six-month~~ ~~(6-month)~~six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member ~~thirty-calendar~~ ~~(30-calendar)~~thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of ~~sixty-calendar~~ ~~(60-calendar)~~sixty (60) calendar day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered 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 experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with 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 illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage 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 member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The

maximum total annual reimbursement for a member's hospice care within a ~~twelve-month~~ ~~(12-month)~~ twelve (12) month period is limited to an amount equivalent to ~~eighty-five~~ ~~(85) percent~~ eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) ADvantage personal care.

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per ~~fifteen-minute~~ ~~(15-minute)~~ fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) Personal emergency response system (PERS).

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the service criteria in (i) through (vi). The member:

(i) ~~member has a recent~~ Has a recent history of falls as a result of an existing medical condition that prevents the member from getting up unassisted from a fall;

(ii) ~~member lives~~ Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

(v) ~~member~~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) ~~PERS service avoids~~Will likely avoid premature or unnecessary institutionalization ~~of the member~~as a result of PERS.

(B) PERS services are billed using the appropriate ~~Healthcare Common Procedure Coding System (HCPCS)~~HCPC procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the AdvantAge approved service plan.

(16) **CD-PASS.**

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from AdvantAge ~~Program Administrative~~program administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

(i) ~~recruits~~Recruits, hires, and, as necessary, discharges the PSA or APSA;

(ii) ~~is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain AdvantAge skilled nursing services assistance with training, when necessary~~Ensures that the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from AdvantAge skilled nurses. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member, and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) ~~determines~~Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and,

within individual budget allocation limits, wages to be paid for the work;

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

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

(B) The services the PSA may provide include:

(i) ~~assistance~~Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) ~~assistance~~Assistance with routine bodily functions, such as:

(I) ~~bathing~~Bathing and personal hygiene;

(II) ~~dresssing~~Dressing and grooming; and

(III) ~~eating~~Eating, including meal preparation and cleanup;

(iii) ~~assistance~~Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

(iv) ~~companion~~Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who ~~when appropriate, orders~~may order home health services, as appropriate. APSA includes assistance with health maintenance activities that may include:

(i) ~~routine~~Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

- (ii) ~~removing~~Removing external catheters, inspecting skin, and reapplication of same;
- (iii) ~~administering~~Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;
- (iv) ~~applying~~Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;
- (v) ~~using~~Using a lift for transfers;
- (vi) ~~manually~~Manually assisting with oral medications;
- (vii) ~~providing~~Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;
- (viii) ~~applying~~Applying non-sterile dressings to superficial skin breaks or abrasions; and
- (ix) ~~using~~Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. 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) ~~processing~~Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
- (ii) ~~other employer-related~~Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;
- (iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;
- (iv) ~~providing~~Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member successfully perform employer-related functions; and
- (v) ~~making~~Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA)

standards.

(E) The PSA service is billed per ~~fifteen minute (15 minute)~~fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per ~~fifteen minute (15 minute)~~fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) Institutional transition services.

(A) Institutional transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed ~~Waiver~~waiver and other State ~~plan~~Plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member transition from institution to home by updating the person-centered service plan, including necessary institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by DHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institutional transition case management services are prior authorized and billed per ~~fifteen minute (15 minute)~~fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case

management services.

(C) Institutional transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

(iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institutional transition services but fails to enter the waiver, any institutional transition services provided are not reimbursable.

(18) Assisted living services (ALS).

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating

philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) ~~rental~~Rental unit availability;

(II) ~~the~~The member's compatibility with other residents;

(III) ~~the~~The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) ~~restrictions~~Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy, and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the Oklahoma

State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person," [Title 63 of the Oklahoma Statutes (O.S.), Section (§) 1-1902.17] and includes assistance with toileting." For ADvantage ALS, assistance with "other

personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits ~~behavior~~behaviors or actions that repeatedly and substantially ~~interferes~~interfere with the rights or well-being of other residents, and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ~~ALC~~ALC's attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ~~ALC~~ALC's attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges and/or DHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, ~~when~~if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk

and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

- (I) ~~a~~A full explanation of the reasons for the termination of residency;
- (II) ~~the~~The notice date;
- (III) ~~the~~The date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;
- (IV) ~~the~~The date the member must leave ALC; and
- (V) ~~notification~~Notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, or lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the ~~landlord-tenant~~landlord-tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper,

register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one (1) lavatory, one (1) toilet, and one (1) bathtub or shower stall.

(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, ~~a. A microwave is an acceptable cooking appliance.~~

(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if ~~member supplied~~ furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per ~~28 Code of Federal Regulations, Part 36, Appendix A~~ Nondiscrimination on the Basis of Disability By Public Accommodations and in in

Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner ~~and be, ensuring that they are~~ insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and ~~Safety~~safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) Staff to resident ratios.

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet the needs of residents and to carry out all of the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage ~~Program~~program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications.

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the ~~Oklahoma~~ Oklahoma's Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in ~~Section 1-1918 of Title 63 of the Oklahoma Statutes~~ 63 O.S. § 1-1918 amended to include additional rights and the clarification of rights as listed in the ADvantage ~~Member Assurances~~ member assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ~~ALC~~ ALC's are those defined by OSDH, per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within ~~five-business~~ ~~(5-business)~~ five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ~~ten-business~~ ~~(10-business)~~ ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per ~~O.S. 43A § 10-104.A~~ 43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must, at the minimum, include preliminary information, the extent of the injury or damage, ~~when~~ if any, and preliminary investigation findings. The final report, at a minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions ~~based on findings~~, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services. The ALC must:

(I) ~~arrange~~ Arrange or coordinate transportation for members to and from medical appointments; and

(II) ~~provide~~ Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose

any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ~~ALS~~ALCs are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage ~~assisted living services~~ALS for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of the daily living(IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ~~ninety-calendar~~ (90-calendar)ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ~~ninety-calendar~~ (90-calendar)ninety (90) calendar days before:

(I) ~~voluntary~~Voluntary cessation of the ALC's ADvantage contract; or

(II) ~~closure~~Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) ~~the~~The proposed ADvantage contract termination date;

(II) ~~the~~The termination reason;

(III) ~~an~~An offer to assist the member secure an alternative placement; and

(IV) ~~available~~Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) ~~the~~The effective date of closure based on the discharge date of the last resident;

(II) ~~a~~A list of members transferred or discharged and where they relocated,; and

(III) ~~the~~The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

**PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN
GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS**

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services (RBMS) in group settings are not covered for adults.

(b) **Children.** RBMS in group settings are covered for children as set forth in this subsection.

(1) **Description.** RBMS are provided by Organized Health Care Delivery Systems (OHCDs) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. RBMS are reimbursed in accordance with established rate methodology as described in the Oklahoma Medicaid State Plan. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one (1) day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDs collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDs must provide concurrent documentation that these services are not duplicative. The OHCDs determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for RBMS.

(A) Any Diagnostic and Statistical Manual of Mental Disorders (DSM) primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file.

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

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

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) Treatment components.

(A) Individual plan of care development. A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within thirty (30) days of admission, for intensive treatment services (ITS) level within seventy-two (72) hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three (3) months, every seven (7) days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have him/her fax back his/her signature; however, the provider obtains the original signature for the clinical file within thirty (30) days. No stamped or Xeroxed signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

- (i) Group therapy;
- (ii) Individual therapy;
- (iii) Family therapy;
- (iv) Alcohol and other drug counseling;

- (v) Basic living skills redevelopment;
- (vi) Social skills redevelopment;
- (vii) Behavior redirection; and
- (viii) The provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one (1) or more sessions totaling one (1) hour or more of treatment per week to children and youth receiving RBMS in group homes. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face-to-face, one-to-one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving RBMS. Group therapy must be a face-to-face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one (1) hour per week in group homes. Group size should not exceed six (6) members and group therapy sessions must be provided in a confidential setting. One half hour (30 min) of individual therapy may be substituted for one (1) hour of group therapy.

(D) **Family therapy.** Family therapy is a face-to-face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The provider agency must provide family therapy as indicated by the resident's individual plan of care. The agency must work with the caretaker to whom the resident will be discharged, as identified by the OHCDs custody worker. The agency must seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider must also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug

dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the individual plan of care. This may include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three (3) hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The provider agency must be able to provide behavior redirection management by agency staff as needed twenty-four (24) hours a day, seven (7) days per week. The agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents twenty-four (24) hours a day, seven (7) days a week.

(4) **Providers.** For eligible RBMS agencies to bill the OHCA for services provided by their staff for behavior management therapies (individual, group, family) as of July 1, 2007, providers must have the following qualifications:

(A) Be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage

and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved ~~Supervision~~supervision to be licensed in one (1) of the above stated areas; or

(B) Be licensed as an advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the Board of Nursing in the state in which services are provided, ~~AND;~~ and

(C) Demonstrate a general professional or educational background in the following areas:

- (i) Case management, assessment and treatment planning;
- (ii) Treatment of victims of physical, emotional, and sexual abuse;
- (iii) Treatment of children with attachment disorders;
- (iv) Treatment of children with hyperactivity or attention deficit disorders;
- (v) Treatment methodologies for emotionally disturbed children and youth;
- (vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (vii) Treatment of children and families with substance abuse and chemical dependency disorders;
- (viii) Anger management; and
- (ix) Crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one (1) of the following areas:

- (i) Bachelor's or master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or
- (ii) ~~A current license as an RN in Oklahoma~~Currently licensed and in good standing as an RN in the state in which services are provided; or
- (iii) Certification as an alcohol and drug counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM diagnosis; or
- (iv) Current certification as a behavioral health case manager from the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and meets OHCA requirements to perform case management services, as described in Oklahoma Administrative Code (OAC) 317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally

recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one (1) of the following areas:

- (i) Trauma-informed methodology;
- (ii) Anger management;
- (iii) Crisis intervention;
- (iv) Normal child and adolescent development and the effect of abuse;
- (v) Neglect and/or violence on such development;
- (vi) Grief and loss issues for children in out of home placement;
- (vii) Interventions with victims of physical, emotional and sexual abuse;
- (viii) Care and treatment of children with attachment disorders;
- (ix) Care and treatment of children with hyperactive, or attention deficit, or conduct disorders;
- (x) Care and treatment of children, youth and families with substance abuse and chemical dependency disorders;
- (xi) Passive physical restraint procedures; or
- (xii) Procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, behavior management staff must have access to consultation with an appropriately licensed mental health professional.