Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 3, 2016 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 09, 2017 and the Board of Directors on March 23, 2017.
Reference: APA WF # 16-33

SUMMARY:
TFC Policy Revisions – The proposed Therapeutic Foster Care revisions remove specific time requirements and add frequency limitations to behavioral health assessment services. Additional revisions clarify oversight requirements for licensure candidates who provide biopsychosocial assessments. Rules are also revised to clarify specific clinical documentation requirements for changes to the service plan prior to the scheduled three month review or update. Revisions also update numerical references and add taglines to align with current Administrative Procedures Act (APA) guidelines.

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

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Tatiana Reed
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 16-33

A. Brief description of the purpose of the rule:

The proposed Therapeutic Foster Care revisions remove minimum time requirements for behavioral health assessment services to allow providers more flexibility in completing biopsychosocial assessments. Revisions also add frequency limitations to clarify limits on how often an assessment can be completed within a single agency. In addition, revisions clarify if an assessment is performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional who is responsible for the member's care. This change will clarify oversight requirements for licensure candidates and ensure quality of care. Rules are also revised to clarify specific clinical documentation requirements when changes need to be made to the service plan prior to the scheduled three month review or update. Revisions also update numerical references and add taglines to align with current Administrative Procedures Act (APA) guidelines.

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:

Licensure Candidates who perform assessments without a countersignature from a licensed behavioral health professional in a therapeutic foster care setting may be affected by the proposed rule. There have been no cost impacts received by the agency from any private or public entities.

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

Licensed behavioral health professionals in a therapeutic foster care setting may benefit from the proposed rule in that they will now have more flexibility in conducting biopsychosocial assessments with SoonerCare clients.

Also, Therapeutic Foster Care agency providers may benefit from the rule, as the revisions clarify documentation requirements for changes made to the service plan prior to the scheduled three month review or update.

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 economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

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:

There are no probable costs or benefits to the agency or to any other agency for the implementation and enforcement of the proposed rule.

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 will not have an economic impact on any political subdivision nor will it require the cooperation of any political subdivision in implementing or enforcing the rule.

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 will not have an adverse impact on small business.

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 taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

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 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:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

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

The rule impact statement was prepared December 7, 2016.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES

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

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

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

(1)**Assessment**.

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other ~~informants, or group of~~ persons resulting in a

written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

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

~~(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours.~~

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

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

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

(ii) Source of information;

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

(iv) Gender;

(v) Birth ~~Date~~date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

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

(xi) Presenting reason for seeking services;

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

(xiii) ~~Signature~~Dated signature of parent or guardian participating in the face-to-face assessment. ~~Signature~~Signatures are required for members over the age of ~~14~~fourteen (14);

(xiv) Bio-Psychosocial information which must include:

(I) Identification of the member's strengths, needs,

abilities and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, ~~Drug~~drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services (DHS) involvement;
(VII) ~~Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;~~Family and social history including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers);
(XV) Present living arrangements;
(XVI) Economic resources; and
(XVII) Current support system, including peer and other recovery supports.

(xv) Mental status and Level of Functioning information, including questions regarding but not limited to the following:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness;
(II) Affective process, such as mood, affect, manner and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
(IV) All related diagnoses from the most recent addition of the DSM.

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

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

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

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

(2) **Individual plan of care requirement.**

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

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

(C) **Qualified professional**. This service is performed by an LBHP or Licensure Candidate.
(D) **Time requirements**. Individual plan of care updates must be conducted face-to-face and are required every three (3) months during active treatment. ~~Updates~~However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.
(E) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:
(i) member strengths, needs, abilities, and preferences~~(SNAP)~~ (SNAP);
(ii) identified presenting challenges, problems, needs and diagnosis;
(iii) specific goals for the member;
(iv) objectives that are specific, attainable, realistic, and time-limited;
(v) each type of service and estimated frequency to be received;
(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria; and
(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date~~;~~.
~~(x) updates to goals, objectives, service provider, services, and service frequency, must be documented within the individual plan of care until the review/update is due.~~
~~(xi) individual plan of care updates must address the following:~~
~~(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis, individual plan of care goals and/ or objectives;~~
~~(II) progress, or lack of, on previous individual plan of care goals and/or objectives;~~
~~(III) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;~~
~~(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;~~

~~(V) change in frequency and/or type of services provided;~~
~~(VI) change in practitioner(s) who will be responsible for providing services on the plan;~~
~~(VII) change in discharge criteria;~~
~~(VIII) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.~~

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

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

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

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

(B) **Crisis/behavior management and redirection**. The provider agency must provide crisis/behavior redirection by agency staff as needed ~~24~~twenty-four (24) hours per

day, ~~7~~seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the ~~Oklahoma Department of Human Services~~OKDHS or the ~~Office of Juvenile Affairs~~OJA must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

(D) ~~**Substance use /chemical dependency use therapy.**~~ **Substance use/chemical dependency use therapy.**

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

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

and skills training. This service is to be provided to the member by a CM II.

(F) **Psychosocial rehabilitation (PSR).**

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

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

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

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

(v) ~~Limitations~~**Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in

settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

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

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

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

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

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

(III) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;
(IV) Member satisfaction with staff intervention(s);
(V) Progress, or barriers made towards goals, objectives;
(VI) New goal(s) or objective(s) identified;
(VII) ~~Signature~~Dated signature of the qualified provider; and
(VIII) Credentials of the qualified provider;

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

(viii) ~~Non-Covered Services~~**Non-Covered Services**. The following services are not considered PSR and are not reimbursable:
(I) room and board;
(II) educational costs;
(III) supported employment; and
(IV) respite.

(G) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment Parent Specialist (TPS). Services rendered by the TPS are limited to ~~1.5~~ one and one half (1.5) hours daily.