TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

(a) **Introduction to HCBS Waivers.** The Medicaid Home and Community-Based Services (HCBS) Waiver programs are authorized in accordance with Section 1915(c) of the Social Security Act.

(1) Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) operates HCBS Waiver programs for persons with mental retardation and certain persons with related conditions. Oklahoma Health Care Authority (OHCA), as the State's single Medicaid agency, retains and exercises administrative authority over all HCBS Waiver programs. Oklahoma Medicaid is referred to hereinafter as SoonerCare.

(2) Each waiver allows for the provision of specific Medicaid-compensable services that assist members to reside in the community and avoid institutionalization.

(3) Waiver services:

(A) complement and supplement services available to members through ~~the Medicaid State Plan~~ SoonerCare or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) can only be provided to persons who are ~~Medicaid~~ SoonerCare eligible, outside of a nursing facility, hospital, or institution; and

(C) are not intended to replace other services and supports available to members.

(4) Any waiver service must be:

(A) appropriate to the member's needs; and

(B) included in the member's Individual Plan (IP).

(i) The IP:

(I) is developed annually by the member's Personal Support Team, per OAC 340:100-5-52; and

(II) contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized in accordance with OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDSD furnishes ~~case management,~~ targeted case management~~,~~

~~and services~~ to members as a Medicaid State Plan service under Section 1915(g)(1) of the Social Security Act in accordance with OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have ~~entered into contractual agreements~~ a current provider agreement with OHCA to provide HCBS for persons with mental retardation or related conditions.

(1) All providers, except pharmacy, specialized medical supplies and durable medical equipment providers must be reviewed by OKDHS DDSD. The review process verifies:

(A) the provider meets the licensure, certification or other standards as specified in the approved HCBS Waiver documents; and

(B) organizations that do not require licensure wishing to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet the standards in the review process will not be approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP. Arrangements for services must be made with the member's case manager.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through ~~(13)~~ (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).

(1) **Dental services.** Dental services are provided per OAC 317:40-5-112.

(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure to practice dentistry in Oklahoma by the Board of Governors of Registered Dentists of Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) oral examination;

(ii) bite-wing x-rays;
(iii) prophylaxis;
(iv) topical fluoride treatment;
(v) development of a sequenced treatment plan that prioritizes~~;~~:
(I) elimination of pain;
(II) adequate oral hygiene; and
(III) restoration or improved ability to chew;
(vi) routine training of member or primary caregiver regarding oral hygiene; and
(vii) ~~any other service recommended by a dentist~~ preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP), in accordance with applicable ~~Home and Community-Based Services (HCBS)~~ Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services**. Nutrition Services are provided per OAC 317:40-5-102.

~~(A) **Minimum qualifications.** Providers of nutrition services must be licensed by the Oklahoma State Board of Medical Examiners and registered as a dietitian with the Commission of Dietetic Registration.~~

~~(B) **Description of services.** Nutrition services include dietary evaluation and consultation in diet to members or their caregivers.~~

~~(i) Services are:~~

~~(I) intended to maximize the member's nutritional health; and~~

~~(II) provided in any community setting as specified in the member's IP.~~

~~(ii) A minimum of 15 minutes for encounter and record documentation is required.~~

~~(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 192 units per Plan of Care year.~~

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation

in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of their practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's IP. The IP must include a physician's prescription.

(ii) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants~~, and advanced practice nurses~~ in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapy assistant within their employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

~~(i) Services provided by occupational therapy assistants must be identified on the claim form by the use of the occupational therapy assistant's individual provider number in the servicing provider field.~~

~~(ii) Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.~~

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapy assistants must ~~be~~ have a current non-restrictive ~~licensed~~ licensure with the Oklahoma State Board of Medical Licensure and Supervision. The physical therapy assistant must be employed by the physical therapist.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and

skeletal/muscular well-being. Physical therapy services may include the use of physical therapy assistants, within the limits of their practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a physician's prescription.

(ii) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants~~, and advanced practice nurses~~ in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapy assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

~~(i) Payment is made for:~~

~~(I) compensable services to the individual physical therapist for direct services; or~~

~~(II) services provided by a qualified physical therapy assistant within his or her employment.~~

~~(ii) Services provided by physical therapy assistants must be identified on the claim form by the use of the physical therapy assistant's individual provider number in the servicing provider field.~~

~~(iii) Payment is:~~

~~(I) made in 15-minute units with a limit of 480 units per Plan of Care year; and~~

~~(II) not allowed solely for written reports or record documentation.~~

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and

behavioral treatment. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group, six person maximum, formats.

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

(ii) Psychological services are authorized for a period not to exceed six months.

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the DDSD area manager based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDSD case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human

Services (OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours (96 units) of service per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours (48 units) may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours (560 units) of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a non-restrictive license to practice medicine in Oklahoma. Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, and medication and prescription management and consultation provided to members who are eligible. Services are provided in any community setting as specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech/language services requires non-restrictive licensure as a speech/language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication

and oral motor/feeding activities provided to members who are eligible. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's IP. The IP must include a physician's prescription.

(i) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants~~, and advanced practice nurses~~ in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet the unique needs of members;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. ' 1025.2), unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight from a contracted agency staff with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment will not be made for:

(I) routine care and supervision that is normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to

the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours.

(iii) Payment does not include room and board or maintenance, upkeep, and improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) DDSD case management supervisor review and approval is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an oversight agency approved by the OHCA. For pre-authorized HTS services, the service:

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

(C) **Coverage limitations.** HTS services are authorized as specified in OAC 317:40-5-110, 317:40-5-111, and 317:40-7-13, and OAC 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment including on call

duties, at the same time they are providing HTS services.

(9) Self Directed HTS (SD HTS).

SD HTS are provided per 317:40-9-1.

(10) Self Directed Goods and Services (SD GS).

SD GS are provided per 317:40-9-1.

~~(9)~~(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to members who are eligible. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a physician's prescription.

(i) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants~~, and advanced practice nurses~~ in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the ~~service recipient's~~ member's IP.

~~(10)~~(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task

oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:

(I) join the general work force; or

(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.

(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.

(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.

(iv) Documentation must be maintained in the record of each member receiving this service noting that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(v) Services include:

(I) center-based prevocational services as specified in OAC 317:40-7-6;

(II) community-based prevocational services as specified in OAC 317:40-7-5;

(III) enhanced community-based prevocational services as specified in OAC 317:40-7-12; and

(IV) supplemental supports as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological

services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per 317:40-7-6.

~~(11)~~(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waiver, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching as specified in OAC 317:40-7-7;

(II) enhanced job coaching as specified in OAC 317:40-7-12;

(III) employment training specialist services as specified in OAC 317:40-7-8; and

(IV) stabilization as specified in OAC 317:40-7-11.

(iii) Supported employment services furnished under HCBS Waiver are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation

Act of 1973 or IDEA must be maintained in the record of each member receiving this service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) payments that are passed through to users of supported employment programs; or

(III) payments for vocational training that are not directly related to a member's supported employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed $25,000 per Plan of Care year. The DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) Therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

~~(12)~~(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current~~, valid contracts~~ provider agreement with OHCA and OKDHS DDSD. Providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2;

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college

level education or full-time equivalent experience in serving persons with disabilities; and

(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(ii) The member's IP must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) DDSD case management supervisor review and approval is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP per OAC 317:40-5-151 and 317:40-5-153.

~~(13)~~(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements set forth in 63 O.S. ' 1-873 *et seq*. and comply with OAC 310:605; and

(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers in order to promote maximum level of independence and function. Services are provided in a non-residential setting separate from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are typically furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the member's IP.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS):

(1) are provided by agencies that have a provider agreement ~~contracted~~ with the Oklahoma Health Care Authority (OHCA);

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

(3) are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDSD director or designee;

(4) are based on the member's need for residential services per OAC 340:100-5-22 and support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:

(1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD);

(2) may provide companion services for one member. Exceptions to serve as companion for two members may be granted only upon approved by the DDSD director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;

(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDSD director or designee;

(4) may not provide companion services to more than two members at any time;

(5) household may not serve more than three members through any combination of companion or respite services;

(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC

317:40-5.

(A) Employment as an agency companion is the companion's primary employment.

(B) The companion may not have other employment when~~:~~

~~(i) the member(s) require enhanced or pervasive level of support;~~

~~(ii)~~ approved to serve two members regardless of the levels of support required by the members.

(C) The companion may have other employment when:

~~(i)~~ ~~the member requires intermittent or close levels of support;~~

~~(ii)~~(i) the personal support Team documents and addresses all related concerns in the member's IP; ~~and~~

~~(iii)~~(ii) the other employment is approved in advance by the DDSD area manager or designee; and

(iii) the companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iv) the companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.

~~(7) approved for other employment may not be employed in another position that requires on-call duties.~~

~~(A)~~ (D) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 days:

(i) the other employment; or

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

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

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

(1) Therapeutic leave:

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

(B) is claimed when:

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

(I) a visit with family or friends without the companion;
(II) vacation without the companion; or
(III) hospitalization, regardless of whether the companion is present; or
(ii) the companion uses authorized respite time;
(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year; and
(D) cannot be accrued from one Plan of Care year to the next.
(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.
(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.
(d) Levels of support for the member and corresponding payment are:
(1) determined by authorized DDSD staff in accordance with levels described in (A) through(D); and
(2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.
(A) **Intermittent level of support**. Intermittent level of support is authorized when the member:
(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;
~~(ii) communicates needs and wants;~~
~~(iii) is~~ (ii) may be able to spend short periods of time unsupervised inside and outside the home; and
~~(iv)~~(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~; and~~.
~~(v) has stable or no ongoing medical or behavioral difficulties.~~
(B) **Close level of support**. Close level of support is authorized when the member:
(i) requires regular, frequent and sometimes constant physical assistance and support ~~or is totally dependent on others~~ to complete daily living skills, such as bathing, dressing, eating, and toileting;
~~(ii) has difficulty or is unable to communicate basic~~

~~needs and wants;~~

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

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

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

(i) is totally dependent on others for:

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

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

(ii) demonstrates ongoing complex medical ~~or behavioral~~ issues requiring specialized training courses per ~~OAC 340:100-3-38.3; and~~ OAC 340:100-5-26; or

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

~~(iv)~~ (iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must:

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

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, ~~and~~ or

(III) have received expedited approval per OAC 340:100-5-57.

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

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

(I) by a licensed professional counselor (LPC) or

professional with a minimum of Masters of Social Work (MSW) degree; and

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

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

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

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

317:40-5-8. Agency companion services service authorization budget

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

(1) The companion receives:

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

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

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

(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on ~~Form 06AC074E~~ the service authorization budget form.

~~(i)~~ (C) Habilitation training specialist (HTS) services:

(i) may be approved by the DDSD director or designee ~~if~~ when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:

(I) sleeping at night; or

(II) working or attending employment services, ~~in~~

~~spite of~~ with documented and continuing efforts by the Team.

(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the placement or provide needed stability to the member; and must be reduced when the situation changes.

~~(ii) HTS units authorized must be reduced when the on-going situation changes.~~

(iii) ~~HTS~~ ~~authorizations~~ must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.

(2) ~~OKDHS Form 6AC074E~~ The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the increase must be:

(A) agreed to by the member and, if applicable, legal guardian;

(B) recommended by the Team; and

(C) submitted with written justification attached to ~~OKDHS Form 06AC074E~~ the service authorization budget form to the DDSD area manager or designee for approval.

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

(A) The back-up plan:

(i) is submitted to the DDSD case manager for approval and attached to the completed ~~OKDHS Form 06AC074E~~ service authorization form;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

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

(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:

(i) knowledgeable about the member;

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

(iii) trained per OAC 340:100-3-38; and

(iv) involved in the member's daily life.

(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, ~~if~~ when trained ~~in accordance with~~ per OAC 340:100-3-38. ~~The~~

~~spouse or other adult residing in the home cannot:~~
~~(i) serve as paid respite staff; and~~
~~(ii) be paid simultaneously with the companion.~~
(D) The spouse or other adult residing in the home cannot serve as paid respite staff.
~~(D)~~ (4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.
~~(4)~~ (5) The member is allowed therapeutic leave ~~in accordance with~~ per OAC 317:40-5-3.

317:40-5-11. Termination of Agency Companion ~~services~~ placement

(a) Designated Developmental Disabilities Services Division (DDSD) staff may terminate an individual agency companion (AC) placement for reasons including, but not limited to:

(1) the ~~service recipient's~~ member's decision to move to a different residence~~. A Team meeting is held to develop an orderly transition plan~~;

(2) the request of the companion~~. A Team meeting is held to develop an orderly transition plan~~;

(3) the Team determines the AC placement is no longer the most appropriate placement for the member;

~~(3)~~(4) failure of the companion to complete tasks related to problem resolution, ~~as described in~~ per OAC 340:100-3-27, as agreed;

~~(4)~~(5) confirmed abuse, neglect, or exploitation of any person;

~~(5)~~(6) breach of confidentiality;

~~(6)~~(7) involvement of the companion in criminal activity, or criminal activity in the home;

~~(7)~~(8) failure to provide for the care and well-being of the ~~service recipient~~ member;

~~(8)~~(9) continued failure to implement the Individual Plan, ~~as described in~~ per OAC 340:100-5-50 through 100-5-58;

~~(9)~~(10) failure to complete and maintain training ~~as described in~~ per OAC 340:10-3-38;

~~(10)~~(11) failure to report changes in the household ~~resulting in the failure of the home to meet standards given in OAC 317:40-5-40~~;

(12) failure or inability of the home to meet standards per OAC 317:40-5-40;

~~(11)~~(13) continued failure to follow applicable Oklahoma

Department of Human Services or Oklahoma Health Care Authority rules;

~~(12)~~(14) decline of the companion's health to the point that he or she can no longer meet the needs of the ~~service recipient~~ member;

~~(13)~~(15) employment by the companion without prior approval by the DDSD area programs manager for residential services; or

~~(14)~~(16) domestic disputes which may result in emotional instability of the ~~person receiving services~~ member.

~~(c)~~(b) Upon termination of the placement~~,~~:

(1) the property of the ~~service recipient~~ member or the state is removed immediately by the ~~service recipient~~ member or his or her designee~~.~~; and

(2) the Team meets to develop an orderly transition plan.

(c) If an individual placement is terminated for reasons identified in (4)-(16) in this Section, DDSD staff will disapprove continued use of the companion.

PART 5. SPECIALIZED FOSTER CARE

317:40-5-64. ~~Closure~~ Termination of a Specialized Foster Care ~~home~~ Provider

(a) In the event that a provider fails to provide services as required by rules or contract, Developmental Disabilities Services Division (DDSD) ~~may, upon written notice to the provider, cancel certification of the home, effective upon receipt of notice~~ notifies the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) Contracts Unit, to terminate the Specialized Foster Care (SFC) provider's contract. Such ~~cancellation~~ termination is not an exclusive remedy but is in addition to any other rights and remedies provided by law.

(b) Possible reasons for ~~closure~~ termination of a ~~Specialized Foster Care (SFC) home~~ provider include, but are not limited to:

(1) provider request;

(2) non-cooperation in determining compliance with standards, policy, or contract;

(3) confirmed abuse, neglect, or exploitation of any other person;

(4) breach of confidentiality;

(5) involvement in criminal activity or criminal activity in the home;

(6) failure to provide for the care and well-being of the

~~service recipient~~ member;
(7) continued failure to implement the ~~service recipient's~~ member's Plan;
(8) failure to complete and maintain required provider training;
(9) failure to report changes in the household ~~resulting in the failure of the home to meet standards~~;
(10) continued failure to follow ~~DDSD~~ OKDHS or OHCA ~~policy~~ rules;
(11) decline of the provider's health to the point that he or she can no longer meet the needs of the ~~service recipient~~ member;
(12) employment by the provider without prior approval by the ~~Developmental Disabilities Services Division (DDSD) SFC supervisor~~ area program manager for residential services;
(13) domestic disputes that may result in emotional instability of the ~~service recipient~~ member; ~~or~~
(14) failure to complete a ~~Plan of Action~~ plan of action, ~~as described in~~ per OAC 317:40-5-63, as agreed~~.~~; or
(15) failure or inability of the home to meet standards per OAC 317:40-5-40.

(c) ~~**Closure**~~ **Termination Process**. When necessary to ~~close an~~ terminate a SFC ~~home~~ provider, the steps described in this Subsection are taken.

(1) ~~SFC~~ DDSD staff documents~~,~~ in the provider case narrative, a summary of the reasons for ~~closure~~ termination and the effective date ~~of the closure~~.

(2) The DDSD ~~Area Manager~~ area manager or designee notifies the case manager and case manager supervisor to ~~make~~ notify legally responsible person(s) and identify other living arrangements, if applicable, for the ~~service recipient~~ member.

(3) The DDSD programs manager for residential services sends a 30-day written notice of the ~~closure~~ termination to the provider.

(A) A copy of the 30-day notice is sent to:
(i) the case manager;
(ii) case management supervisor;
(iii) DDSD ~~Area Manager~~ area manager;
(iv) DDSD State Office; and
(v) ~~Division of Children and Family Services (DCFS)~~Children and Family Services Division (CFSD), if applicable.

(B) A copy of the narrative is sent with the written notice to DDSD State Office;

(4) DDSD State Office notifies the ~~Oklahoma Health Care Authority~~ (OHCA) and the OKDHS Contracts Unit to ~~close~~ terminate the provider's contract.

PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications

(a) **Applicability.** The rules in this Section apply to architectural modification (AM) services authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.** Architectural Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC) formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

~~(2)~~(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

~~(3)~~(5) are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) lack of a less expensive equivalent, such as assistive technology, that meets the member's needs; and

(E) safety and suitability of the home.

~~(4)~~(6) are limited to modifications of two different residences within any seven year period beginning with the member's first request for an approved architectural modification service;
~~(5)~~(7) are provided with assurance of plans for the member to remain in the residence for at least five years;
~~(6)~~(8) may be denied when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.
(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.
(B) Members needing home modification services and provider agencies assisting members to locate rental property identify several homes, when possible, for screening in order to select a home with the fewest or most cost effective modifications;
~~(7)~~(9) ~~Architectural modifications~~ are provided to eligible members with the homeowner's signed permission;
~~(8) are specific to the member's unique needs~~
~~(9)~~(10) are not authorized to modify homes solely for family or staff convenience or for cosmetic preference;
~~(10)~~(11) are provided on finished rooms complete with wiring and plumbing;
~~(11)~~(12) ~~architectural modifications~~ services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDSD division administrator or designee in exceptional circumstances; and
~~(12)~~(13) are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., '85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

(c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:
(A) DDSD area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or
(B) a licensed occupational therapist or physical therapist, at the request of designated DDSD area office resource development staff or area program supervisory staff, when the requested architectural modification exceeds or requires a variance to applicable national standards for persons with physical disabilities, or when

such expertise is deemed necessary by DDSD area office resource development staff or area program supervisory staff.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) are necessary to ensure the health, welfare, and safety of the member; and

(B) provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

(d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed;

(B) following all applicable building codes; and

(C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance; and

(C) worker's compensation insurance <u>or affidavit of exemption</u>.

(5) All modifications meet national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

(6) Contractors complete construction in compliance with written assessment recommendations from the:

(A) DDSD area office resource development staff with

architectural modification experience; or

(B) a licensed professional.

(7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

(8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) All exterior wooden ramps are constructed of number two pressure treated wood.

(B) Surface of the ramp has a rough, non-skid texture.

(C) Ramps are assembled by the use of deck screws.

(D) Hand rails on ramps, if required, are sanded and smooth.

(E) Ramps can be constructed of stamped steel.

(F) Support legs on ramps are no more than six feet apart.

(G) Posts on ramps must be set or anchored in concrete.

(9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(10) DDSD area office resource development staff inspect any or all architectural modification work, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that has been modified and the member will no longer be sharing the home, the member whose Plan of Care authorized the modifications is given the first option of remaining in the residence.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class when a written agreement between the homeowner and DDSD director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDSD director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) Square footage is not added to the home as part of an architectural modification.

(2) Architectural modifications are not performed during construction or remodeling of a home.

(3) Modifications not authorized by the OKDHS include, but are not limited to:

(A) roofs;
(B) installation of heating or air conditioning units;
(C) humidifiers;
(D) water softener units;
(E) fences;
(F) sun rooms;
(G) porches;
(H) decks;
(I) canopies;
(J) covered walkways;
(K) driveways;
(L) sewer lateral lines or septic tanks;
(M) foundation work;
(N) room additions;
(O) carports;
(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;
(Q) non-adapted home appliances;
(R) carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or

(S) a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless needed by the member to move between the house and vehicle.

(g) **Approval or denial of architectural modification services.** DDSD approval or denial of an architectural modification service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request provided by the DDSD case manager to DDSD area office resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;

(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101;

(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months; and

(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) The DDSD area office:

(A) authorizes architectural modification services less than $2500~~;~~ when the plan of care is less than the state office reviewer limit; and

(B) provides all required information to the DDSD State Office architectural modification programs manager for authorization of services ~~costing~~ when the plan of care is more than the area office limit or is $2500 or more.

(3) Architectural modifications may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals**. The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

317:40-5-102. Nutrition Services

(a) ~~**Purpose**~~ **Applicability**. The rules in this Section apply to ~~are established to ensure that~~ nutrition services authorized for members ~~to sustain quality of life and ensure optimal nutritional status are provided to individuals with developmental disabilities~~ who receive services through Home and Community-Based Services (HCBS) ~~Waiver~~ Waivers operated by the

Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) ~~services~~.

(b) **General information.** Nutrition services include nutritional evaluation and consultation to members and their caregivers, are intended to maximize the member's health and are provided in any community setting as specified in the member's Individual Plan (IP). Nutrition services must be prior authorized, included in the member's Individual Plan (IP) and arrangements for this service must be made through the member's case manager. Nutrition service contract providers must be licensed in the state where they practice and registered as a dietitian with the Commission of Dietetic Registration. Each dietitian must have a current provider agreement with the Oklahoma Health Care Authority (OHCA) to provide Home and Community Based Services, and a SoonerCare provider agreement for nutrition services. Nutrition Services are ~~based on the individual's need~~ provided per Oklahoma Administrative Code (OAC) 340:100-3-33.1. ~~as specified by the Individual Plan and include evaluation of the service recipient's nutritional status.~~

~~(1) If nutrition services from funding sources other than Waiver services are available to the service recipient, the service recipient uses those services before using Waiver services.~~ In order for the ~~service recipient~~ member to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.

~~(2) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services.~~

~~(A) Refusal of nutrition services must be documented in the Individual Plan.~~

~~(3) If the service recipient has been receiving nutrition services and nutritional status is currently stable, the Team may specify that nutrition services are not needed. The Team specifies individual risk factors for the (member) service recipient that would necessitate resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the service recipient's status regarding these factors.~~

~~(B) If the service recipient has been receiving nutrition services and nutritional status is currently stable, the Team may specify that nutrition services are not needed. The Team specifies individual risk factors for the service recipient that would necessitate resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the service~~

~~recipient's status regarding these factors.~~

(1) The member must be assessed by the case manager to have a possible eating problem or nutritional risk.

(2) The member must have a physician's order for nutrition services current within one year.

(3) Per OAC 340:100-5-50 through 58, the team identifies and addresses member needs.

~~(3) Staff of the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) and contract agents implement procedures for nutritional risk identification, implementation of needed services, and nutritional risk monitoring to maintain and improve the nutritional health status of each person served.~~

(4) Nutrition services may include evaluation, planning, consultation, training and monitoring.

(5) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services per OAC 340:100-3-11. Refusal of nutrition services must be documented in the Individual Plan.

(6) A minimum of 15 minutes for encounter and record documentation is required.

(7) A unit is 15 minutes.

(8) Nutrition services are limited to 192 units per Plan of Care year.

~~(c) **Services for persons not receiving residential supports.** If the service recipient does not receive residential supports as defined in OAC 340:100-5-22.1, or group home services:~~

~~(1) the Individual Plan must justify the need for nutrition services as described in OAC 340:100-3-33.1, Criteria to establish service necessity; and~~

~~(2) procedures described in subsections (e) through (ji) are followed unless other procedures are approved in writing by the DDSD area manager or designee.~~

~~(d) **Services for persons receiving residential supports.** If the service recipient receives residential supports as defined in OAC 340:100-5-22.1, or group home services:~~

~~(1) the service recipient must have an updated OKDHS Form DDS-7, Physical Status Review (PSR), in accordance with OAC 340:100-5-26, identifying an eating problem or nutritional risk. indicated by a score of 3 or 4 on Eating, 4 on Gastrointestinal, 4 on Skin Breakdown, 4 on bowel Function, or 3 or 4 on the Nutrition section of the PSR. The Team must address these risks in the Individual Plan and identify appropriate professional oversight; and~~

~~(2) the requirements in subsections (e) through (j) of this Section are followed.~~

~~(e)~~ (c) **~~Assessment~~** **Evaluation**. When arranged by the case manager, the ~~The~~ nutrition ~~therapist~~ services contract provider evaluates the member's ~~service recipient's~~ nutritional status and completes the ~~OKDHS Form DDS-40,~~ Level of Nutritional Risk Assessment.

(1) The evaluation ~~assessment~~ must include, but is not limited to:

(A) health, diet, and behavioral history impacting on nutrition;

(B) clinical measures including body composition and physical assessment.

(C) dietary assessment, including:

(i)nutrient needs;

(ii) eating skills;

(iii) nutritional intake; and

(iv) drug-nutrient interactions; ~~and~~

(D) recommendations to address nutritional risk needs, including:

(i) outcomes;

(ii) strategies;

(iii) staff training; and

(iv) program monitoring and evaluation.

(2) The nutrition services contract provider ~~therapist~~ and other involved professionals make recommendations for achieving positive nutritional outcomes based on the risks identified on the OKDHS Level of Nutritional Risk Assessment. ~~form DDS-40.~~

(3) The nutrition services contract provider ~~therapist~~ sends a copy of the Level of Nutritional Risk Assessment ~~DDS-40~~ to the case manager within ten working days of receipt of the authorization.

(4) If the ~~assessment~~ evaluation shows the member ~~service recipient~~ rated as ~~A~~High Nutritional Risk@, the nutrition services contract provider ~~therapist~~ sends a copy of the Level of Nutritional Risk Assessment ~~DDS-40~~ to the DDSD area nutrition therapist or DDSD area professional support services designee as well as the case manager within 10 working days of receipt of the authorization.

~~(f)~~(d) **Planning.** The DDSD case manager, in conjunction with the Team, reviews the identified nutritional ~~issues~~ risks that impact the member's ~~service recipient's~~ life.

(1) Desired nutritional outcomes are developed and integrated into the Individual Plan using the least restrictive, least

intrusive, most normalizing measures that can be carried out across environments.
(2) The Team member(s) identified responsible in the Individual Plan develops methods to support the nutritional outcomes, which may include:
(A) Stragegies;
(B) Staff training; or
(C) Program monitoring.
(3) When the member has been receiving nutrition services and nutritional status is currently stable and the Team specifies that nutrition services are no longer needed, the Team will identify individual risk factors for the member that would indicate consideration of the resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the members status regarding these factors.
~~(1)~~(4) Any ~~service recipient with a PSR score of 3 or above on Section A, Eating,~~ member who receives paid 24 hour per day supports and requires constant physical assistance and mealtime intervention to eat safely, or is identified for risk of choking or aspiration must have an individualized mealtime assistance plan developed and reviewed at least annually by the Team member(s) identified responsible in the Individual Plan. Team members may include a nutrition services contract provider and a speech therapy contract provider or occupational therapy contract provider with swallowing expertise (mealtime therapists). Documentation should delineate responsibilities to insure there is no duplication of services. The mealtime assistance plan includes but is not limited to:
(A) a physician ordered diet ~~or meal plan~~;
(B) diet instructions;
~~(B)~~ (C) positioning needs;
~~(C)~~ (D) ~~adaptive equipment~~ assistive technology needs;
~~(D)~~ (E) communication needs;
(F) eating assistance techniques;
(G) supervision requirements;
~~(E) food presentation;~~
~~(F)~~ (H) documentation requirements;
~~(G)~~ (I) monitoring requirements; and
~~(H)~~ (J) training and assistance ~~requirements~~.
~~(2) In accordance with OAC 340:100-5-26, the Team:~~
~~(A) discusses any gastrostomy or jejunostomy tube placement, including discussion of less intrusive alternatives, prior to implementation of the proposed~~

~~procedure; or~~

~~(B) reviews emergency placement of any gastrostomy or jejunostomy tube within five working days after placement.~~

(5) For those members receiving paid 24 hour per day supports and nutrition through a feeding tube, the Team develops and implements strategies for tube feeding administration that enables members to receive nutrition in the safest manner and for oral care that enables optimal oral hygiene and oral-motor integrity as deemed possible per OAC 340:100-5-26. The Team reviews the member's ability to return to oral intake following feeding tube placement and annually thereafter in accordance with the member's needs.

~~(3) The Team annually develops, and documents in the Individual Plan a review of, a plan for return to oral intake, in accordance with individual needs, for each service recipient who receives nutrition through a tube.~~

~~(4) Desired nutritional outcomes are developed and integrated into the Individual Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.~~

~~(5) The Team member(s) identified responsible in the Individual Plan develops methods to support the nutritional outcomes, which include:~~

~~(A) implementation strategies;~~

~~(B) staff training; and~~

~~(C) program monitoring.~~

~~(g)~~(e) **Implementation, Consultation and Training.** Strategies are implemented by the assigned person within a designated time frame established by the Team based on individual need(s).

(1) Direct support staff members are trained ~~in accordance with~~ per the Individual Plan and OAC 340:100-3-38.

(2) All special diets, nutritional supplements, and aids to digestion and elimination must be prescribed and reviewed at least annually by a physician.

(3) Consultation to members and their caregivers is provided as specified in the IP.

~~(h)~~(4) ~~**Documentation.**~~ Program documentation ~~as determined necessary by the Team~~ is maintained in the member's ~~service recipient's~~ home record for the purpose of evaluation and monitoring. ~~The professional provider(s) sends documentation regarding the service recipient's progress on the nutrition outcomes, program concerns, and recommendations for remediation of any problem area to the case manager each month, or as often as deemed necessary by the Team.~~

(5) The contract professional provider(s) sends documentation

regarding the member's program concerns, recommendations for remediation of any problem area and progress notes to the case manager per OAC 340:100-5-52.

~~(i) **Evaluation and monitoring.** A review to evaluate the success of the program is performed at least once each month or as deemed necessary in the Individual Plan by the professional(s) designated by the Team. The area manager or designee may require a specified schedule for service recipients with a high nutritional risk.~~

~~(1)~~(A) The designated professional(s) reviews the program data submitted for:

~~(A)~~ (i) completeness;

~~(B)~~ (ii) consistency of implementation; and

~~(C)~~ (iii) positive outcomes.

~~(2) DDSD professional support services personnel provide administrative oversight and quality assurance monitoring on an ongoing basis to service recipients with eating risk or nutritional risk identified through the PSR using:~~

~~(A) on-site visits; and~~

~~(B) record reviews.~~

~~(3)~~(B) When a member ~~service recipient~~ is identified by the Level of Nutritional Risk Assessment ~~DDS-40~~ to be at high nutritional risk, he or she receives increased monitoring by~~:~~

~~(A)~~ the nutrition services contract provider ~~therapist~~ and health care coordinator, as determined necessary by the Team:~~; and~~

~~(B) the DDSD area nutrition therapist or DDSD area professional support services designee.~~

~~(4)~~(C) Significant changes in nutritional status must be reported to the case manager by the health care coordinator.

~~(5)~~(D) The Level of Nutritional Risk Assessment ~~DDS-40~~:

~~(A)~~(i) is used by the ~~contract~~ nutrition services contract provider to reassess ~~service recipients~~ members at high risk on a quarterly basis; and

~~(B)~~(ii) must be submitted by the ~~contract~~ nutrition services contract provider to the DDSD area nutrition therapist or DDSD area professional support services designee within 15 days following the end of each quarter ~~(March, June, September, December)~~.

~~(6) The DDSD area nutrition therapist or designee, in conjunction with DDSD support services professionals, provides technical assistance to resolve individual nutrition issues and makes recommendations for additional technical assistance if needed.~~

~~(j) **Technical Assistance.** Professional contract providers~~

~~serving as management consultants provide technical assistance as authorized. Technical assistance may be requested using OKDHS form DDS-41, Physical-Nutritional Management Consultation Request, by the Team or DDSD support services staff to address:~~

~~(1) unresolved nutritional management issues;~~

~~(2) gastrostomy or jejunostomy tube placement or removal;~~

~~(3) individualized mealtime assistance plan development; or~~

~~(4) any aspect of assessment, planning, implementation, evaluation, or monitoring of nutrition services.~~

317:40-5-104. Specialized medical supplies

(a) **Applicability.** The rules in this section apply to specialized medical supplies provided through Home and Community Based Services (HCBS) Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

~~(a)~~(b) **General ~~requirements~~ information.** Specialized medical supplies include supplies specified in the plan of care ~~that meet the criteria given in this Section.~~ that enable the member to increase his or her ability to perform activities of daily living.

~~(1)~~ Specialized medical supplies include the purchase of ancillary supplies not available ~~under the Medicaid State Plan~~ through SoonerCare.

(1) Specialized medical supplies must be included in the member's plan and arrangements for this service must be made through the member's case manager. Items reimbursed with Home and Community Based Services ~~(HCBW)~~ (HCBS) funds are in addition to any supplies furnished ~~under the Medicaid State Plan~~ by SoonerCare.

(2) Specialized medical supplies meet the criteria for service necessity given in OAC 340:100-3-33.1.

(3) All items meet applicable standards of manufacture, design, and installation.

(4) Specialized medical supplies providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement ~~contract~~ with the Oklahoma Health Care Authority~~.~~, and be registered to do business in Oklahoma or the state in which they are domiciled. Providers must enter into the agreement giving assurance of ability to provide products and services and agree to the audit and inspection of all records concerning goods and services provided.

(5) Items that can be purchased as specialized medical supplies include:

(A) incontinence supplies, as described in subsection (b) of this Section;
(B) nutritional supplements;
(C) supplies for respirator or ventilator care;
(D) decubitus care supplies;
(E) supplies for catheterization; and
(F) supplies needed for health conditions.

(6) Items that cannot be purchased as specialized medical supplies include:
(A) over the counter medications(s);
(B) personal hygiene items;
(C) medicine cups;
(D) items that are not medically necessary; and
(E) prescription medication(s)~~;~~. ~~and~~
~~(F) items available through the Medicaid State Plan. Items available through the Medicaid State Plan must be exhausted before waiver-funded services can be accessed.~~

(7) Specialized medical supplies must be:
(A) necessary to address a medical condition;
(B) of direct medical or remedial benefit to the ~~service recipient~~ member;
(C) medical in nature; and
(D) consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

~~(b)~~ (c) **Limited coverage.** Items available in limited quantities through specialized medical supplies include:
(1) incontinence wipes, 300 wipes per month;
(2) non-sterile gloves, as approved by the Team;
(3) disposable underpads, 60 pads per month; and
(4) incontinence briefs, 180 briefs per month.
(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the Team.
(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the DDSD nurse when the ~~service recipient~~ member has a medical condition that precludes implementation of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.

~~(c)~~ (d) **Exceptions.** Exceptions to the requirements of this Section are explained in this subsection.
(1) When a ~~service recipient's~~ member's Team determines that the ~~service recipient~~ member needs medical supplies that:
(A) are not available ~~under the Medicaid State Plan~~

through SoonerCare and for which no Health Care Procedure Code exists, the case manager e-mails pertinent information regarding the ~~service recipient's~~ member's medical supply need to the programs manager responsible for Specialized Medical Supplies. The e-mail includes all pertinent information that supports the need for the supply, including but not limited to, quantity and purpose; or

(B) exceed the limits stated in subsection ~~(b)~~ (c) of this Section, the case manager ~~submits the request for additional supplies to the DDSD area manager~~ documents the need in the Individual Plan for review and approval per 340:100-33.

(2) Approval or denial of exception requests is made on a case by case basis and does not override the general applicability of this Section.

(3) Approval of a specialized medical supplies exception does not exceed one plan of care year.

317:40-5-110. Authorization for Habilitation Training Specialist Services

(a) Habilitation Training Specialist (HTS) Services are:

(1) authorized as a result of needs identified by the team and informed selection by the ~~service recipient~~ SoonerCare member;

(2) shared among ~~service recipients~~ SoonerCare members who are members of the same household or being served in the same community location; ~~and~~

(3) authorized only during periods when staff are engaged in purposeful activity which directly or indirectly benefits the service recipient. Staff must be physically able and mentally alert to carry out the duties of the job. At no time are HTS services authorized for periods during which the staff are allowed to sleep~~.~~;

(4) not authorized to be provided in the home of the HTS unless the ~~service recipient~~ SoonerCare member and HTS reside in the same home; and

(5) directed toward the development or maintenance of a skill in order to achieve a specifically stated outcome. The service provided is not a function which the parent would provide for the individual without charge as a matter of course in the relationship among members of the nuclear family when the member resides in a family home.

(b) HTS Services may be provided in a group home as defined in 317:40-5-152 or community residential service settings defined

in OAC 340:100-5-22.1 including:

(1) agency companion services as described in OAC 317:40-5-1 through 40-5-39;

(2) as provided in accordance with Daily Living Supports policy at OAC 317:40-5-150; and,

(3) as provided in accordance with Specialized Foster Care Policy at OAC 317:40-5-50 through 40-5-76; or

(4) services for people with Prader Willi syndrome.

(c) HTS Services are based on need and limited to no more than 12 hours per day per household in any setting other than settings described in OAC 340:100-5-22.1, Community Residential Supports, except with approval in accordance with OAC 340:100-3-33, Service authorization, that the increased services are necessary to avoid institutional placement due to:

(1) the complexity of the family or caregiver support needs. Consideration must be given to:

(A) the age and health of the caregiver;

(B) the number of household members requiring the caregiver's time; and

(C) the accessibility of needed resources; and

(2) the resources of the family, caregiver, or household members that are available to the service recipient. Consideration must be given to the number of family members able to assist the caregiver and available community supports; and

(3) the resources of other agencies or programs available to the ~~service recipient~~ SoonerCare member or family. Consideration must be given to services available from:

(A) the public schools;

(B) the Oklahoma Health Care Authority;

(C) the Oklahoma Department of Rehabilitative Services;

(D) other OKDHS programs; and

(E) services provided by other local, state, or federal resources.

(d) When it appears that approval of an exception is needed to prevent institutional placement, the case manager submits the request which identifies the circumstances supporting the need for an exception to the area manager.

(e) The DDSD area manager or designee must approve, deny, or notify the case manager of issues preventing approval within 10 working days.

(f) HTS providers may not perform any job duties associated with other employment, including on call duties, at the same time they are providing HTS services.

(g) HTS services are limited to no more than 40 hours per week

when the HTS resides in the same home as the service recipient. If additional hours of service are needed, they must be provided by someone living outside the home.

(h) When the member is out of the home for school, work, adult day services or other non-HTS supported activities, the total number of hours of HTS and hours away from the home cannot exceed 12 hours per day unless an exception is granted in accordance with subsection c of this policy.

(i) In accordance with OAC 340:100-3-33.1, services must be provided in the most cost effective manner. When the need for HTS services is expected to continue to exceed 9 hours daily, cost effective community residential services must be considered and requested in accordance with OAC 317:40-1-2. For adults, continuation of non-residential services in excess of 9 hours per day for more than one plan of care year will not be authorized except:

(1) when needed for members who receive services through the Homeward Bound Waiver;

(2) when determined by the division administrator or designee to be the most cost effective option; or

(3) as a transition period of 120 days or less to allow for identification of and transition to a cost effective residential option. Members who do not wish to receive residential services will be assisted to identify options that meet their needs within an average of 9 hours daily.

317:40-5-111. Authorization for Habilitation Training Specialist Services in the Homeward Bound Waiver

(a) Habilitation Training Specialist (HTS) Services are authorized as a result of needs identified by the Personal Support Team and informed service recipient selection.

(b) HTS Services may be provided in the Homeward Bound waiver in service settings including:

(1) agency companion services as described in OAC 317:40-5-1 through OAC 317:40-5-39;

(2) daily living supports as described in OAC 317:40-5-153;

(3) specialized foster care as described in OAC 317:40-5-50 through OAC 317:40-5-76;

(4) group home services as described in OAC ~~340:100-6~~ 317:40-5-152; and

(5) the class member's own home, family's home, or other community residential setting.

(c) HTS services are authorized only during periods when staff are engaged in purposeful activity that directly or indirectly benefits the person receiving services.

(1) Staff must be physically able and mentally alert to carry out the duties of the job.
(2) At no time are HTS services authorized for periods during which the staff are allowed to sleep.

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult Day Services. This service is available through the Community Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. Individuals who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work toward the goals of:

(1) promoting the ~~individual's~~ member's maximum level of independence;
(2) maintaining the ~~individual's~~ member's present level of functioning as long as possible, preventing or delaying further deterioration;
(3) assisting the ~~individual~~ member in achieving the highest level of functioning possible;
(4) providing support, respite, and education for families and other caregivers; and
(5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible ~~service recipients~~ members whose teams have determined the service is appropriate to meet their needs. ~~Service recipients~~ Members must:

(1) require ongoing support and supervision in a safe environment when away from their own residence;
(2) be 18 years of age or older; and
(3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

(1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;
(2) comply with OAC 310:605, Adult Day Care Centers;
(3) allow DDSD staff to make announced ~~or~~ and unannounced visits to the facility during the hours of operation;
(4) provide the DDSD ~~Case Manager~~ case manager a copy of the individualized plan of care; ~~and~~

(5) submit incident reports ~~in accordance with~~ per OAC 340:100-3-34~~.~~;
(6) maintain a copy of the member's Individual Plan (Plan);
(7) submit Oklahoma Department of Human Services (OKDHS) Adult Day Services Progress Report Form 06WP046E to the DDSD case manager by the tenth of each month for the previous month's services, for each member receiving services; and
(8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The ~~service recipient's~~ member's ~~Individual Plan (IP)~~ Plan contains detailed descriptions of services to be provided and documentation of hours of services. All services must be authorized in the ~~IP~~ Plan and reflected in the approved plan of care. Arrangements for care must be made with the ~~service recipient's~~ member's case manager.

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-150. Daily Living Supports for the Community Waiver

(a) **Introduction.** Daily Living Supports (DLS) are provided by an agency, approved by the Developmental Disabilities Services Division (DDSD), that has a valid Oklahoma Health Care Authority contract for the service.

(1) Daily Living Supports require meeting the daily support needs of the ~~service recipients~~ members living in the home.

(A) In accordance with the needs of the ~~service recipient~~ member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the ~~service recipient~~ member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports also include assistance with cognitive tasks or provision of services, ~~in accordance with~~ per OAC 340:100-5-57, to prevent a ~~service recipient~~ member from harming self or others.

(C) Daily Living Supports also include:

(i) the provision of staff training ~~in accordance with~~ per OAC 340:100-3-38, to meet the specific needs of the ~~service recipient~~ member;

(ii) program supervision that includes the 24-hour availability of response staff to meet schedules and unpredictable needs;

(iii) program oversight;

(iv) assisting the ~~service recipient~~ member in

obtaining services and supplies;

(v) developing and assuring emergency plans are in place; and

(vi) coordinating overall safety and supports in the home.

(D) Direct support services are coordinated and shared among household members receiving services to meet identified needs and are provided by staff who do not live in the home.

(2) DLS include an average of eight hours daily of direct support services. ~~Service recipients~~ Members needing direct support services exceeding an average of eight hours per day identify, with case manager assistance, roommates willing to share Daily Living Supports services. Additional direct support services are considered in accordance with subsection (f) of this Section.

(b) **Eligibility.** Daily Living Supports are provided to ~~individuals~~ members who:

(1) are eighteen years of age or older, unless approved by the Director of OKDHS or designee;

(2) need an average of at least eight hours of direct support services daily;

(3) are participants in the DDSD Community waiver, ~~described in~~ per OAC 317:40-1-1;

(4) need community residential services outside the family home; and

(5) do not simultaneously receive any other community residential or group home services.

(c) **Service requirements.** Daily Living Supports must be:

(1) included in the ~~service recipient's~~ member's Individual Plan ~~in accordance with~~ per OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the ~~service recipient~~ member;

(2) authorized in the ~~service recipient's~~ member's Plan of Care;

(3) provided by the contracted provider agency chosen by the ~~service recipient~~ member or guardian;

(4) delivered in accordance with DDSD Community Residential Supports rules at OAC 340:100-5-22.1; and

(5) provided directly to the ~~service recipient~~ member.

(d) **Home Requirements.** Daily Living Supports are provided to eligible ~~service recipients~~ members living outside their family's home in a home that:

(1) is leased or owned by the ~~service recipient(s)~~ member(s)

or the ~~service recipient's~~ member's legal guardian; and

(2) houses no more than three individuals living together. Exceptions for homes shared by four ~~service recipients~~ members may be granted in writing by the DDSD director or designee.

(e) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed when the ~~service recipient~~ member is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDSD policy found at OAC 340:100; and

(3) provide for the welfare of all ~~service recipients~~ members living in the home.

(4) ensure that trained staff are available to the member as described in the individual plan.

(f) **Criteria for direct support staff services beyond eight hours per day.** Additional direct support services including Habilitation Training Specialist(HTS), Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section must be approved by the DDSD area manager or designee.

(1) In order to receive additional direct support staff services, the ~~service recipients~~ members living together must have insufficient supports including hourly nursing services to meet their needs for support.

(A) Additional direct support staffing may be authorized if the ~~service recipient~~ member is living with two roommates but still has medical or behavior support needs beyond the capacity of staff shared with the other roommates, including participation by staff providing hourly nursing services.

(B) Additional direct support staffing is only provided to a ~~service recipient~~ member who has one or no roommates if:

(i) the area manager or designee documents that behavior support issues make it impossible for the ~~service recipient~~ member to have a roommate; or

(ii) in accordance with paragraph (2) of this subsection.

(C) If a ~~service recipient~~ member lives with one or no roommates or requires a second support staff to meet his or her intensive behavior support needs, the Team must provide clear documentation that the ~~service recipient~~ member has difficulty establishing compatible relations with others as evidenced by:

(i) severe and persistent emotional and behavioral disturbances; or

(ii) a history of difficulty sharing a home with others.

(2) The area manager or designee may grant conditional approvals for staff beyond an average of eight hours per day per ~~service recipient~~ member:

(A) due to the temporary or permanent departure of a roommate while another roommate is being identified; or

(B) to facilitate emergency residential placement of a person needing services while roommates are being identified.

(3) As part of the annual review, the case manager must:

(A) re-evaluate the ~~service recipient's~~ member's additional direct support services; and

(B) implement any alternative solutions that would promote independence and reduce intrusion by paid workers as much as possible. Documentation of such evaluations and the implementation of alternative solutions is included in the case manager's record.

(g) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each ~~service recipient~~ member.

(1) The provider agency claims one unit of service for each day during which the ~~service recipient~~ member receives Daily Living Supports. A day is defined as the period between 12:00 a.m. and 11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a ~~service recipient~~ member changes provider agencies, only the outgoing service provider agency claims for the day that the ~~service recipient~~ member moves.

(h) **Billing for other support services.** Additional support services such as HTS, Intensive Personal Supports, or Homemaker Services may be provided to a ~~service recipient~~ member receiving Daily Living Supports, if:

(1) the additional support services have been authorized in the ~~service recipient's~~ member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the ~~service recipient~~ member. The direct support staffing is averaged across the week when the needs of the ~~service recipients~~ members in the household vary from day to day; and

(2) an average of eight hours of DLS has already been provided to the ~~service recipient~~ member each day that week.

(A) The provider cannot bill for additional support

services unless 56 hours of DLS have been provided during the week to the ~~service recipient~~ member.

(B) If support services are provided to multiple ~~service recipients~~ members residing in the same household at the same time, the provider agency cannot count these hours toward each ~~service recipient's~~ member's 8-hour minimum.

317:40-5-152. Group home services for persons with mental retardation or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to persons who are eligible 18 years of age or older. Upon approval of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) director or designee, persons younger than 18 may be served.

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

(2) Group homes must be licensed by DDSD in accordance with Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

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

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may be approved only by the DDSD director or designee to resolve a temporary emergency when no other resolution exists, or in a community living group home when the needs are so extensive that additional supports are needed for specific activities at identified times and the resulting plan of care is the most cost effective option. A weekly average of eight hours per day of direct contact staff must be provided per resident receiving community living group home services before HTS services may be claimed.

(b) **Minimum provider qualifications.** Approved providers must have a current ~~contract~~ provider agreement with the Oklahoma Health Care Authority (OHCA) to provide DDSD Home and Community-Based Services (HCBS) ~~Waiver~~ for persons with mental retardation or related conditions.

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

(2) Group home staff must:

(A) complete the OKDHS DDSD-sanctioned training curriculum per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening per

OAC 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

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

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

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

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

(2) Group home providers:

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

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

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

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

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

(d) **Coverage limitations.** Group home services are provided up to 366 days per year.

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

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

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

(A) Members who receive community living home services ~~have~~:

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

~~(ii) a diagnosis of severe or profound mental retardation requiring frequent assistance in the performance of activities necessary for daily living or continual supervision to ensure the member's health and safety; or~~

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

~~(iii) complex needs requiring frequent:~~

~~(I) assistance in the performance of activities necessary for daily living, such as frequent assistance of staff for positioning, bathing, or other necessary movement;~~ or

~~(II)~~(iii) require supervision and training in appropriate social and interactive skills, due to on-going behavioral issues ~~in order~~ to remain included in the community.

(B) Services offered in a community living home include:

(i) 24-hour awake supervision when a member's IP indicates it is necessary; and

(ii) program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(C) Services may be approved for individuals in a traditional group home at the community living service rate if the member has had a change in health status or behavior and meets requirements to receive community living home services. Requests to receive community living home services are sent to the DDSD Community Services Residential Unit.

(3) **Alternative group homes.** Alternative group homes serve no more than four members who have evidence of behavioral or emotional challenges in addition to mental retardation and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria per in OAC 340:100-5-22.6.

(B) A determination must be made by the DDSD Community Services Unit that alternative group home services are appropriate.

For example, three hours of service provided simultaneously by a single direct contact staff to three ~~residents~~ members in the same household may only be counted as three hours of service for one of the ~~service recipients~~ members, not three hours for each ~~resident~~ member.

(i) **Therapeutic leave.** Therapeutic leave is a ~~Medicaid~~ SoonerCare payment made to the Daily Living Supports contract provider to enable the ~~service recipient~~ member to retain personal care services.

(1) Therapeutic leave is claimed when the ~~service recipient~~

member does not receive Daily Living Supports services for 24 consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff ~~are~~ may be present with the ~~service recipient~~ member in the hospital as approved by the ~~service recipient's~~ member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) A ~~service recipient~~ member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) To promote continuity of direct support staff in the ~~service recipient's~~ member's absence, the provider pays the staff member the salary that he or she would have earned if the ~~service recipient~~ member were not on therapeutic leave if the provider is unable to provide an alternative work opportunity.

317:40-5-153. Daily Living Supports for the Homeward Bound Waiver

(a) **Introduction.** Daily Living Supports are provided by an agency with a valid ~~OHCA~~ Oklahoma Health Care Authority (OHCA) contract~~, approved by DDSD, for the service~~.

(1) Daily Living Supports require meeting the daily support needs of the ~~people~~ member living in the home.

(A) In accordance with the needs of the class member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the ~~person~~ member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports are provided by staff that do not live in the home ~~also~~ and include assistance with cognitive tasks or provision of services to prevent ~~an individual~~ a member from harming self or others, in accordance with the needs of

(C) Daily Living Supports also include:

(i) the provision of staff training per OAC 340:100-3-

30 to meet the specific needs of the ~~service recipient~~ member;

(ii) program supervision that includes 24-hour availability of response staff to meet schedules and unpredictable needs; ~~and~~

(iii) program oversight~~.~~;

(iv) assisting the member in obtaining services and supplies;

(v) developing and assuring emergency plans are in place;

(vi) coordinating overall safety and supports in the home; and

(vii) assisting members with personal money management.

(2) Daily Living Supports are used to provide and fund up to eight hours per day of supports for class members receiving supported living services ~~as detailed in~~ per OAC 340:100-5-22.5.

(b) **Eligibility.** Daily Living Supports, as described in this Section, are provided to ~~individuals~~ members who:

(1) are members of the class certified in Case Number 85-C-437-E, U.S. District Court for the Northern District of Oklahoma;

(2) receive community residential services in their own home; and

(3) do not simultaneously receive any other community residential or group home services.

(c) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed to all ~~service recipients~~ members living in the home when one or more ~~service recipients~~ members is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDSD policy found at OAC 340:100; ~~and~~

(3) provide for the welfare of all ~~service recipients~~ members living in the home~~.~~ ; and

(4) ensure that trained staff are available as described in the member's individual plan.

(d) **Criteria for direct support staff services in the Homeward Bound Waiver beyond eight hours per day.** Additional direct support services including HTS, Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section, are provided based on needs identified by the Personal Support Team and are considered in accordance with subsection (f) of this Section.

(e) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each ~~individual receiving services~~ member.

(1) The provider agency claims one unit of service for each day the ~~individual~~ member receives Daily Living Supports.

(2) Providers must claim at least monthly for all days that Daily Living Supports were actually provided during the preceding month. Claims must not be based on budgeted amounts.

(3) When ~~an individual~~ a member changes provider agencies, only the outgoing service provider agency claims for the day that the ~~individual~~ member moves.

(f) **Billing for other support services.** Additional support services such as HTS, Intensive Personal Supports, or Homemaker Service may be provided to a member ~~The provider agency may claim separately for additional support services such as HTS, Intensive Personal Supports, or Homemaker Services provided to an individual~~ receiving Daily Living Supports, if:

(1) additional support services have been authorized in the ~~person's~~ member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the member. The direct support staffing is averaged across the week when the needs of the members in the household vary from day to day; and

(2) an average of eight hours of DLS has already been provided to the member each day that week. ~~of direct staff support, excluding Nursing, have already been provided to the person that day. If support services are provided to multiple individuals residing in the same household at the same time, the provider agency cannot count these hours toward each individual's eight-hour minimum. For example, three hours of HTS provided simultaneously by a single direct contact staff to three residents in the same household may only be counted as three hours of HTS for one of the individuals, not three hours for each resident.~~

(g) **Therapeutic leave.** Therapeutic leave is a Medicaid payment made to the Daily Living Supports contract provider to enable the ~~service recipient~~ member to retain direct support services.

(1) Therapeutic leave is claimed when the ~~service recipient~~ member does not receive Daily Living Supports services for 24 consecutive hours because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are

present or not. Daily living supports staff ~~are~~ may be present with the ~~individual~~ member in the hospital as approved by the ~~person's~~ member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) ~~An individual~~ A member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) If, because of the ~~service recipient's~~ member's absence, the direct support staff ~~member~~ is unable to work, the provider pays the staff ~~member~~ the salary that he or she would have earned if the ~~service recipient~~ member were not on therapeutic leave.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-12. Enhanced rates

An Enhanced Rate is available for both Community-Based Group Services and Group Job Coaching Services~~.~~ when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per OAC 340:100-5-56 and assessment of medical, nutritional, and mobility needs and:

(1) ~~Eligibility for an enhanced rate is determined by~~ Team assessment ~~as detailed in~~ per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and ~~subsection (d) of~~ OAC 340:100-5-26 of the ~~service recipient's~~ member's needs.

(2) ~~To be eligible for the enhanced rate,~~ the ~~service recipient~~ member must:

(A) have a protective intervention plan that:

(i) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(ii) has been approved by the State Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff ~~in accordance with subsection (g) of~~ per OAC 340:100-5-57; and

(iii) has been reviewed by the Human Rights Committee (HRC) ~~in accordance with~~ per OAC 340:100-3-6;

(B) have procedures included in the Individual Plan which address dangerous behavior that places the ~~service recipient~~ member or others at risk of serious physical harm but are neither restrictive or intrusive procedures as defined in OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to assure that positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

(D) have two or more of the circumstances given in this subparagraph.

(i) The ~~service recipient~~ member has medical support needs which are rated at Level 4, Level 5, or Level 6 on the Physical Status Review (PSR), explained in OAC 340:100-5-26 or a comparable level of high medical needs as documented in the Plan.

(ii) The ~~service recipient~~ member has nutritional needs ~~supported by the PSR~~ requiring tube feeding or other dependency for food intake which must occur in the employment setting.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in OAC 317:40-7 are:

(1) approved in accordance with OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan ~~(IP)~~ (Plan) process per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded on Oklahoma Department of Human Services (OKDHS) Form 06WP047E, Exception Request for Waiver Employment Services, by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, adult day services per OAC 317:40-5-113, or a combination of both, per OAC 317:40-7-15, includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans;

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and

(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(e) Within ten working days of the annual ~~IP~~ Individual Planning or interim meeting, the DDSD case manager sends OKDHS Form 06WP047E to area employment services staff, who reviews the form to ensure all criteria per OAC 317:40-7-21 are met. If criteria are:

(1) not met, employment services staff returns OKDHS Form 06WP047E with recommendations to the DDSD case management supervisor and case manager for resubmission; or

(2) met, employment services staff returns OKDHS Form 06WP047E to the case management supervisor to resume the

approval process and input of units on the member's Plan of Care.

(f) Exception requests per OAC 340:40-7-21(f) are documented by the DDSD case manager after Team consensus and submitted via OKDHS Form 06WP047E to the DDSD area manager within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDSD area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

(g) The DDSD director or designee may review exceptions granted ~~in accordance with~~ per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.

(iii) The ~~service recipient~~ member has mobility needs, ~~supported by the PSR,~~ such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology has been evaluated for the current employment program and determined not feasible by the DDSD division director or designee; or

(E) reside in alternative group home as described in OAC 317:40-5-152.

(3) The enhanced rate can be claimed only if the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38.

(4) There are no exceptions for the enhanced rate other than as allowed in this Section.