Oklahoma Health Care Authority

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

OHCA COMMENT DUE DATE: March 3, 2023

The proposed policy changes are Permanent Rules. The proposed policy changes were presented at the January 3, 2023, Tribal Consultation. The proposed rule changes will be presented at a Public Hearing on March 7, 2023. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on March 2, 2023, and the OHCA Board of Directors on March 22, 2023.

SUMMARY:
Developmental Disabilities Services (DDS) Policy Changes - The proposed revisions to the DDS policy will add and/or revoke language to reflect amendments made to Community and Homeward Bound waiver amendments and the IHSW-A and IHSW-C renewals. These amendments and renewals were recently approved by CMS and made effective July 1, 2022. Revisions will also correct formatting and grammatical errors, as well as align policy with current business practices.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 162 and 1025.1 et seq. of Title 56 of the Oklahoma Statues

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 22-24B

A. Brief description of the purpose of the rule:

The proposed revisions to the Oklahoma Human Services Developmental Disability Services specialized foster care (SFC) section will add new language to outline new criteria for Remote services and Agency Companion services, as well as provide ne SFC standards and criteria. Other revisions will add optometry benefits, which will allow routine eye examination and purchase of corrective lenses. Additional revisions add language to support the increase of the public transportation limit from $5,000 to $25,000. Additional, update and remove outdated language and definitions, remove obsolete references, revoke/combine sections to comply with Executive Order 2020-03, which requires state agencies to reduce unnecessary and outdated rules. Revisions will also correct formatting and grammatical errors, as well as align policy with current business practices.

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

Persons most affected by the proposed rule changes will be DDS members who are in need of offering agency companion services, specialized foster care and assistive technology services. This rule should not place any cost or burden on private or public entities.

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

Persons who will benefit from a portion of this proposed rule change will be DDS members twenty-one (21) years of age and older access to optometry benefits.

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

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

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

DDS program staff has determined that the proposed rule changes are budget neutral.

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

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

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

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

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

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

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

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

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

The Agency does not anticipate any detrimental effect on the public health, safety, or environment if the proposed rule changes are not implemented.

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

Prepared:

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

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

(a) **General Information.** RS services are intended to promote a member's independence. RS services are provided in the member's home, family home, or employment site to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's Individual Plan (Plan) and arrangements for this service are made through the case manager. Authorization to provide RS must be obtained from the Developmental Disabilities Services (DDS) division director or designee.

(1) RS services are:

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

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

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

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

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

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

(1) Live-video feed~~;~~.

(2) Live-audio feed~~;~~.
(3) Motion-sensing monitoring~~;~~.
(4) Radio-frequency identification~~;~~.
(5) Web-based monitoring~~;~~.
(6) Personal Emergency Response System ~~(PERS) ;~~.
(7) Global positioning system ~~(GPS)~~ monitoring devices~~; or~~.
(8) Any other device approved by the ~~Developmental Disabilities Services (DDS)~~DDS director or designee.

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

(1) An assessment for RS ~~Assessment~~services is completed:
(A) Annually;
(B) Prior to RS implementation; and
(C) As required by ongoing progress and needs assessments.

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

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

(4) The use of camera or video equipment in the member's bedroom or other private area is prohibited.

(5) RS services are provided in real time by awake staff at a monitoring base using the appropriate connection, not by a recording. While RS is provided the RS staff does not have duties other than ~~remote supports~~RS.

(6) RS equipment used in the member's residence includes a visual indicator to the member that the system is on and operating.

(7) RS provider agencies must immediately notify in writing, the member's residential provider agency, vocational provider agency, assigned DDS case manager, or guardian of activity in the household~~, who~~ that could potentially compromise the member's health or safety.

(8) Emergency response provider agency staff records are maintained, per Oklahoma Administrative Code (OAC) 340:100-3-40.

(9) RS provider records are maintained for seven (7) calendar years or until any pending litigation involving the service recipient is completed, whichever occurs last and include at a minimum:
(A) The member's name;
(B) The staff's name who delivered the service;
(C) Service dates;
(D) Service begin and end times;
(E) Provider's location;
(F) Description of services provided or observation note;
(G) Method of contact with member; and
(H) The member's current photograph.

(10) RS providers must have:
(A) Safeguards in place including, but not limited to:

(i) A battery or generator to insure continued coverage during an electrical outage at the member's home and monitoring facility;
(ii) Back-up procedures at the member's home and monitoring site for:
(I) Prolonged power outage;
(II) Fire;
(III) Severe weather; ~~and~~
(IV) The member's personal emergency~~.~~; and
(iii) The ability to receive alarm notifications, such as home security, smoke, or carbon monoxide at each residence monitored, as assessed by the ~~team~~Team as necessary for health and safety~~.~~; and
(B) Two-way audio communication allowing staff monitors to effectively interact with, and address the member's needs in each residence;
(C) A secure Health Insurance Portability and Accountability Act (HIPAA)-compliant network system requiring data authentication, authorization, and encryption to ensure access to computer vision, audio, sensor, or written information is limited to authorized staff or ~~team~~Team members per the Plan;
(D) A current file for each member receiving RS services including:
(i) The member's photograph;
(ii) The member's Plan;
(iii) The member's demographics; and
(iv) Any other pertinent data to ensure the member's safety~~.~~; and
(E) Capability to maintain all video and make it available to OKDHS staff upon request for a minimum of twelve (12) calendar months. OKDHS may require an extended timeframe when necessary.

(d) **RS staff requirements.** RS staff:
(1) May not have any assigned duties other than oversight and member support at the time they are monitoring;
(2) Receive member specific training per the member's Plan prior to providing support to a member;
(3) Assess urgent situations at a member's home or employment site and call 911 first when deemed necessary; then contact the member's residential provider agency or employment provider agency designated emergency response staff; or the member's natural support designated emergency response person while maintaining contact with the member until persons contacted or emergency response personnel arrive on site;
(4) Implement the member's Plan as written by the Team and document the member's status at least hourly;
(5) ~~Complete~~Completes and ~~submit~~submits incident reports, per OAC 340:100-3-34, unless emergency backup staff is engaged;
(6) ~~Provide~~Provides simultaneous support to no more than ~~sixteen (16)~~thirty (30) members;
(7) ~~Are~~Is eighteen (18) years of age and older; and
(8) ~~Are~~Is employed by an approved RS agency.

(e) **Emergency response requirement.**
(1) Emergency response staff ~~are~~is employed by a provider agency with a valid OHCA SoonerCare (Medicaid) provider agreement to provide residential services, vocational services or habilitation training specialist (HTS) services to ~~OKDHS/DDS~~OKDHS DDS HCBS Waiver members and:

(A) May not have any assigned duties other than oversight and support of members at the time they are assigned as response staff;
(B) ~~Receive~~Receives all trainings required, per OAC 340:100-3-38.1, for members in residential settings; OAC 340:100-3-38.2 for members in employment settings; or OAC 340:100-3-38.3, for members in non-residential settings per the Plan prior to providing support;
(C) ~~Provide~~Provides a response on site at the member's residence or employment site within twenty (20) minutes when contacted by RS staff unless a shorter timeframe is indicated in the member's Plan;
(D) ~~Have~~Has an on-call back-up person who responds when the primary response staff engaged at another home or employment site is unable to respond within the specified time frame;
(E) ~~Provide~~Provides written or verbal acknowledgement of a request for assistance from the RS staff;
(F) ~~Complete~~Completes and document emergency drills with the member quarterly when services are provided in the member's home;
(G) ~~Implement~~Implements the Plan as written and document each time they are contacted to respond, including the nature of the intervention and the duration;
(H) ~~Complete~~Completes incident reports, per OAC 340:100-3-34; and
(I) ~~Are~~Is eighteen (18) years of age and older.

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

(f) **Service limitations.** RS is limited to twenty-four (24) hours per day. RS is not provided simultaneously with HTS~~ services~~, homemaker~~ services~~, ~~agency companion services, group home services, specialized foster care,~~ respite, intensive personal supports~~ services~~, daily living supports, per OAC 340:100-5-22.1, or employment services, per OAC 340:100-17 ~~group job coaching, or where foster care is provided to children~~. RS ~~can be provided in conjunction with daily living supports, individual job coaching, employment stabilization services, and center and community based services~~may not be provided to members receiving specialized foster care or agency companion services, per OAC 340:100-5.22.1, or group home services, per OAC 340:100-6.

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

(2) RS services are shared among ~~OKDHS/DDS~~OKDHS DDS Waiver members of the same

household in a residential setting. RS provider agencies may only bill for one (1) member of a household at a time. Only one (1) ~~remote supports~~RS provider per household~~;~~.

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

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

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

~~(2) Leaves the system operating until the emergency response staff arrives; and~~

~~(3) Turns off the system once relieved by the emergency response staff.~~

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

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

(B) Leaves the system operating until the emergency response staff arrives; and

(C) Turns off the system once relieved by the emergency response staff; or

(2) At the discretion of the RS provider when services do not meet the health or behavioral needs of the individual.

(A) A thirty (30) calendar day termination notice must be provided to the member and the Team prior to discontinuing services so alternative services can be arranged.

(B) Services must continue to be provided to the service recipient until the Team confirms all essential services are in place.

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

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

(a) ACS are:

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

(2) Provider Agency independent contractors and provide a shared living arrangement developed to meet the member's specific needs that include supervision, supportive assistance, and training in daily living skills, and integrates the member into the shared experiences of a family in a home owned or rented by the companion;

(3) Available to members eighteen (18) years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under eighteen (18) years of age may be served with approval from ~~the~~ Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services (DDS) director or designee; and

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

(b) ~~An agency companion:~~Households are limited to one (1) individual companion provider.

Exceptions for two individual companion providers are allowed in a household when each provides companion services to different members. Exceptions may be approved by the DDS director or designee. Agency companions may not simultaneously serve more than four (4) members through any combination of companion or respite services. An agency companion:

(1) ~~Must have~~Has an approved home profile, per OAC 317:40-5-3, and contract with a DDS-approved provider agency;

(2) May provide companion services for one (1) member. Exceptions to serve as companion for two (2) members may be approved by the DDS director or designee. Exceptions for up to two (2) members may be approved when members have an existing relationship and to separate them would be detrimental to their ~~well being~~well-being and the companion demonstrates the skill and ability required to serve as companion for two (2) members. Exceptions for additional members may be granted when the DDS director or designee determines an emergency situation exists and there is no other resolution, and the companion demonstrates the skill and ability required to serve as a companion~~.~~;

~~(3) Household is limited to one (1) individual companion provider. Exceptions for two (2) individual companion providers in a household who each provide companion services to different members may be approved by the DDS director or designee;~~

~~(4)~~ (3) May not provide companion services to more than two (2) household members at any time; and

~~(5) Household may not simultaneously serve more than four (4) members through any combination of companion or respite services.~~

~~(6)~~(4) May not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member, per OAC 317:40-5.

(A) The companion may have employment when:

(i) Employment is approved in advance by the DDS area residential services ~~program~~ programs manager;

(ii) ~~Companion's~~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

(iii) ~~Companion provides assurance~~The companion ensures the employment is such that the member's needs ~~will be~~are met by the companion ~~should~~if the member's outside activities ~~be~~are disrupted.

(B) If, after receiving approval for employment, authorized DDS staff determines the employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within thirty (30) calendar days:

(i) His or her employment; or

(ii) His or her contract as an agency companion.

(C) Homemaker, habilitation training specialist, and respite services are not provided for the companion to maintain employment.

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

(1) Therapeutic leave:

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

(B) Is claimed when the:

(i) Member does not receive ACS for twenty-four (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) Companion uses authorized respite time; and
(C) Is limited to no more than fourteen (14) consecutive, calendar days per event, not to exceed sixty (60) calendar days per Plan of Care (POC) year; and
(D) Cannot be carried over from one (1) POC year to the next.
(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate.
(3) The provider agency pays the agency companion the payment he or she would earn if the member were not on therapeutic leave.
(d) The companion may receive a combination of hourly or daily respite per POC year equal to seven-hundred and twenty (720) hours.
(1) The daily respite rate is used when respite is provided for a full twenty-four (24) hour day. A day is defined as the period between 12:00 am and 11:59 pm.
(2) The hourly respite rate is used when respite is provided for a partial day.
(3) The provider may serve more than one (1) member through shared staffing, but may not bill HTS or the hourly respite rate for multiple members at the same time.
(e) Habilitation ~~Training Specialist~~training specialist (HTS) services:
(1) May be approved by the DDS director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of the member not:
(A) Sleeping at night; or
(B) Working or attending employment, educational, or day services; and
(2) May be approved when a time-limited situation exists in which the companion provider is unable to provide ACS, and the provision of HTS ~~will maintain~~maintains the placement or ~~provide~~provides needed stability for the member, and must be reduced when the situation changes;
(3) Must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers; and
(4) Must be documented by the Personal Support Team (Team) and the Team must continue efforts to resolve the need for HTS.
(f) The contractor model does not include funding for the provider agency for the provision of benefits to the companion.
(g) The agency receives a daily rate based on the member's level of support. Levels of support for the member and corresponding payment are:
(1) Determined by authorized DDS staff per levels described in ~~(A) through(D); and~~OAC 317:40-5-3(g)(2)(A) through (C); and
(2) Re-evaluated when the member has a change in ~~agency~~individual companion providers ~~that includes a change in 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) May be able to spend short periods of time unsupervised inside and outside the home; and~~
~~(iii) Requires assistance with medication administration, money management,~~

~~shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.~~

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

(i) ~~Regular frequent, and sometimes constant physical assistance and support to complete~~Minimal to extensive assistance to complete daily living skills, such as bathing, dressing, eating, and toileting~~;~~.

(ii) Extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~; or~~.

(iii) Assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

~~(C)~~(B) **Enhanced level of support**. Enhanced level of support is authorized when the member requires the level of assistance outlined in (g)(2)~~(B)~~(A) and meets at least one (1) of the ~~following~~criteria in (i) through (iii) of this subparagraph. 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; or

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

(iii) Has behavioral issues that ~~requires~~require a protective intervention protocol (PIP) with a restrictive or intrusive procedure, per OAC 340:100-1-2. The PIP must:

(I) Be approved by the Statewide Human Rights Behavior Review Committee ~~(SHRBRC)~~, per OAC 340:100-3-14; or

(II) Have received ~~expedited~~temporary approval, per OAC 340:100-5-57~~;~~.

~~(iv) Meets the requirements of (g)(2)(C)(i) through (ivii); and does not have an available personal support system. The need for this service level:~~

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

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

~~(D)~~(C) **Pervasive level of support.** Pervasive level of support ~~requires the level of assistance outlined in (g)(2)(C), and~~ is authorized when the member is in OKDHS Child Welfare Services custody and efforts to place in traditional foster care have failed due to the extensive level of support required by the member. It is reevaluated only when the member is eighteen (18) years of age or older and his or her individual companion provider changes.

(i) This level of support may continue to be authorized when the member requires:

(I) The level of assistance outlined in (g)(2)(B); and

(II) Additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges.

~~(i)~~(ii) ~~Requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided~~Providers of this level of support:

(I) ~~By~~Deliver direct support to the companion by a licensed or certified behavioral health professional ~~counselor (LPC) or professional~~ with a minimum of ~~Masters of Social Work (MSW) degree~~a master's degree; ~~and~~

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

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

(IV) Market, recruit, screen, and train potential companions for the identified member.

~~(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.~~

(h) Authorization for payment of ACS is contingent upon receipt of:

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

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

(3) The Plan;

(4) The POC; and

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

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

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

PART 5. SPECIALIZED FOSTER CARE STANDARDS

317:40-5-50. Purpose of Specialized Foster Care ~~Scope~~(SFC)

(a) ~~Specialized Foster Care (SFC)~~SFC provides up to ~~24~~twenty-four (24) hours per day of in-home residential habilitation services funded through the Community Waiver or the Homeward Bound Waiver. SFC serves individuals ~~ages~~ three (3) years of age and older. SFC provides an individualized living arrangement in a family setting including up to ~~24~~twenty-four (24) hours per day of supervision, supportive assistance, and training in daily living skills.

(b) SFC is provided in a setting that best meets the member's specialized needs~~ of the service recipient~~.

(c) Members in SFC have a written plan that addresses visitation, reunification, or permanency

planning, and which may also address guardianship as the member approaches eighteen (18) years of age.

(d) As per the requirements in (1) through (4) of this subsection, SFC providers:

(1) Are approved through the home profile process described in Oklahoma Administrative Code (OAC) 317:40-5-40;

(2) Have a current Home and Community-Based Services (HCBS) Waiver contract with the Oklahoma Health Care Authority; and

(3) Have a current Fixed Rate Foster Home Contract for room and board reimbursement with Developmental Disabilities Services (DDS) when:

(A) The SFC member is a child; or

(B) Required by the adult ~~member's~~SFC recipient's Personal Support Team (Team).

(e) A child in Oklahoma Human Services (OKDHS) or tribal custody who is determined eligible for HCBS Waiver services, per OAC 317:40-1-1, is eligible to receive SFC services if the child's special needs cannot be met in a Child Welfare Services (CWS) foster home.

(1) SFC provides a temporary, stable, nurturing, and safe home environment for the child while OKDHS plans for reunification with the child's family.

(2) In the event reunification is not achievable, SFC may be provided on a long-term basis while other more permanent living arrangements are sought.

(3) When the court has established a specific visitation plan, the CWS specialist informs the SFC provider, the member, the DDS case manager, and the natural family of the visitation plan.

(A) The SFC provider cooperates with the visitation plan between the child and family as prescribed by the court or the member's Team.

(B) The reunification effort is the joint responsibility of the:

(i) CWS worker;

(ii) DDS case manager;

(iii) Natural family; and

(iv) SFC family.

(C) For children in OKDHS custody, CWS and DDS work together to determine the need for guardianship. When it has been established that a legal guardian is in the child's best interest, both programs work together to locate a guardian.

(f) SFC is a temporary service provided to children who are not in OKDHS custody when SFC services are needed to prevent institutionalization.

(1) ~~SFC intent is to allow the member's family relief that cannot be satisfied by respite services provisions or other in-home supports~~SFC is intended to allow relief for the member's family that cannot be satisfied by respite services provisions or other in-home supports.

(2) SFC provides a nurturing, substitute home environment for the member while plans are made to reunify the family.

(3) Visitation with the family is a part of the reunification efforts for non-custody children. Visitation must not be intrusive to the SFC home.

(4) Parents of a child receiving SFC services must comply with the requirements listed in (A) through (D) of this paragraph.

(A) Natural or adoptive parents retain the responsibility for their child's ongoing involvement and support while the child is in SFC.

(i) The parents are required to sign a written agreement allowing OKDHS to serve

as the representative payee for the child's Social Security Administration (SSA) benefits, other government benefits, and court-authorized child support.

(ii) SSA and other government benefits, and child support are used to pay for room and board. HCBS services do not pay for room and board ~~maintenance~~.

(B) Parental responsibilities of a child receiving voluntary SFC are to:

(i) Provide respite to the SFC provider;

(ii) Provide transportation to and from parental visitation;

(iii) Provide a financial contribution toward their child's support;

(iv) Provide in kind supports, such as disposable undergarments, if needed, clothing, recreation, birthday and holiday presents, school supplies, and allowances or personal spending money;

(v) Follow the visitation plan as outlined by the member's Team, per OAC 317:40-5-52;

(vi) Maintain ongoing communication with the member and SFC provider by letters, telephone calls, video conferencing, or email;

(vii) Be available in an emergency;

(viii) Work toward reunification when appropriate;

(ix) Provide written consent for medical treatments as appropriate;

(x) Attend medical appointments, when possible, and keep informed of the member's health status;

(xi) Participate in the member's education plan per Oklahoma State Department of Education regulations; and

(xii) Be present for all Team meetings.

(C) When moving out of Oklahoma, parents of a child receiving voluntary SFC are responsible for taking their minor child with them, since the child is no longer eligible for services because he or she is no longer an Oklahoma resident.

(D) For children eighteen (18) years of age and younger, the case manager reports to CWS if the family moves out of Oklahoma without taking their child with them or if the family cannot be located.

(g) SFC is an appropriate living arrangement for many adults. The decision to use SFC for an adult is based on the member's need for residential support as described in the member's Individual Plan (Plan).

(1) In general, SFC is appropriate for members who have not experienced family life. A child served in SFC may continue to receive services in the home indefinitely after turning ~~18~~eighteen (18) years of age.

(2) The member who receives SFC services lives in the provider's home.

(3) Visitation with the adult member's family is encouraged and arranged according to the member's preference. Visitation is not intrusive to the SFC home.

(h) When natural or other unpaid supports are not available, the SFC provider may request respite support.

(1) Respite units do not replace the responsibilities of the SFC provider on a regular basis.

(2) All respite units must be justified in the member's Plan process.

(3) No more than seven-hundred and twenty (720) hours annually may be authorized unless approved by the DDS director or designee.

(A) The daily respite rate is used when respite is provided for a full twenty-four (24) hour day. A day is defined as the period between 12:00 a.m. and 11:59 p.m..

(B) The hourly respite rate is used when respite is provided for a partial day.
(C) The provider may serve more than one (1) member through shared staffing, but may not bill habilitation training specialist (HTS) services or the hourly respite rate for multiple members at the same time.
(4) No spouse or other adult living in the provider household may serve as paid respite staff.
(5) Consideration is given to authorizing additional respite hours when providing additional relief represents the most cost-effective placement for the member and:
(A) There are multiple members living in the home;
(B) The member has an on-going pattern of not sleeping at night; or
(C) The member has an on-going pattern of not working or attending employment services, in spite of continuing efforts by the Team.
(i) HTS services may be approved by the DDS director or designee when providing SFC with additional staffing support represents the most cost-effective placement for the member when:
(1) There is an ongoing pattern of not sleeping at night; or
(2) There is an ongoing pattern of not working or attending employment, educational, or day services;
(3) There are multiple members living in the home;
(4) A time-limited situation exists in which the foster parent is unable to provide SFC, and the provision of HTS maintains the placement or provides needed stability for the member, and must be reduced when the situation changes;
(5) Must be reviewed annually or more frequently as needed; and
(6) Must be documented by the Team and the Team must continue efforts to resolve the need for HTS.
(j) A member may receive therapeutic leave for no more than fourteen (14) consecutive days per event, not to exceed sixty (60) calendar days per Plan of Care year.
(1) The payment for a day of therapeutic leave is the same amount as the per diem rate for SFC services.
(2) Therapeutic leave is claimed when the member does not receive SFC services for twenty-four (24) consecutive hours from 12:00 am to 11:59 pm because of:
(A) A visit with family or friends without the SFC provider;
(B) Vacation without the SFC provider; or
(C) Hospitalization.

317:40-5-60. Relief support for providers of Specialized Foster Care [REVOKED]

~~When natural or other unpaid supports are not available, the Specialized Foster Care (SFC) provider may request relief support.~~
~~(1) Relief units do not replace the responsibilities of the SFC provider on a regular basis.~~
~~(2) All relief units must be justified in the service recipient's Plan process.~~
~~(3) No more than 720 hours annually may be authorized unless approved by the Developmental Disabilities Services Division director or designee.~~
~~(4) No spouse or other adult living in the provider household may serve as paid relief staff.~~
~~(5) Consideration is given to authorizing additional relief hours when providing additional relief represents the most cost-effective placement for the service recipient and:~~
~~(A) there are multiple service recipients living in the home;~~
~~(B) the service recipient has an on-going pattern of not sleeping at night; or~~
~~(C) the service recipient has an on-going pattern of not working or attending~~

~~employment services, in spite of continuing efforts by the Team.~~

PART 9. SERVICE PROVISIONS

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

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

(b) **General information.**

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

(A) Visual alarms;

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

(C) Telephone amplifying devices;

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

(E) Tap~~e~~ recorders;

(F) Talking calculators;

(G) Specialized lamps;

(H) Magnifiers;

(I) Braille writers;

(J) Braille paper;

(K) Talking computerized devices;

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

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

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

(O) Mobility and positioning devices including:

(i) Wheelchairs;

(ii) Travel chairs;

(iii) Walkers;

(iv) Positioning systems;

(v) Ramps;

(vi) Seating systems;

(vii) Standers;

(viii) Lifts;

(ix) Bathing equipment;

(x) Specialized beds; ~~and~~

(xi) Specialized chairs; and

(P) Orthotic and prosthetic devices, including:

(i) Braces;

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

(iii) Splints; and

(Q) Environmental controls or devices;

(R) Items necessary for life support, and devices necessary for the proper functioning of

such items, including durable and non-durable medical equipment not available through SoonerCare (Medicaid); and

(S) DevicesEnabling technology devices to protect the member's health and safety or support increased independence in the home, employment site or community can include, but are not limited to:

(i) Motion sensors;
(ii) Smoke and carbon monoxide alarms;
(iii) Bed and/or or chair sensors;
(iv) Door and window sensors;
(v) Pressure sensors in mats on the floor;
(vi) Stove guards or oven shut off systems;
(vii) Live web-based remote supports;
(viii) Cameras;
(ix) Automated medicationMedication dispenser systems;
(x) Software to operate accessories included for environmental control;
(xi) Software applications;
(xii) Personal Emergency Response Systems (PERS) or Mobile;mobile;
(xiii) Emergency Response Systems (MER);
(xiv) Global positioning system (GPS) monitoring devices;
(xv) Radio frequency identification;
(xvi) Computers, smart watches and tablets; and
(xvii) Any other device approved by the Developmental; andDDS director or designee;
(xviii) Disabilities Services (DDS) director or designee.

(T) Eye glasses lenses, frames or visual aids.

(2) AT services include:

(A) Sign language interpreter services for members who are deaf;
(B) Reader services;
(C) AuxillaryAuxiliary aids;
(D) Training the member and provider in the use and maintenance of equipment and auxiliary aids;
(E) Repair of AT devices; and
(F) Evaluation of the member's AT needs.; and
(G) Eye examinations.

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

(4) AT devices are provided by vendors with a Durable Medical Equipment (DME)durable medical equipment or other appropriate contract with the Oklahoma Health Care Authority (OHCA).

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

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

professional board, when applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) **Assessments.** Recommendations for enabling technology devices are completed by the DDS programs manager for remote supports or their designee. Assessments for AT devices or services are performed by a licensed, professional service provider and reviewed by other providers whose services may be affected by the device selected. A licensed, professional service provider must:

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

(A) Household items or toys;

(B) Equipment loan programs;

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

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

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

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

(B) History of use of similar AT, and his or her current ability to use the device~~and for the next five (5) years~~; and

(C) Outcomes; and

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

(A) A device review;

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

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

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

(E) The features and specifications of the device necessary for the member, including

rationale for why other alternatives are not available to meet the member's needs; and

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

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

(e) **AT device retrieval.** When a member no longer needs an AT device, OKDHS DDS staff may retrieve the device.

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

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

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

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

(2) Allows the member receiving services to:

(A) Improve or maintain health and safety;

(B) Participate in community life;

(C) Express choices; or

(D) Participate in vocational training or employment; and

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

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

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

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

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

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

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

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

(1) Trampolines;

(2) Hot tubs;

(3) Bean bag chairs;

(4) Recliners with lift capabilities;

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

(6) Massage tables;

(7) Educational games and toys; or

(8) Generators.

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

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

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

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

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

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

(2) The designated AT-experienced resource development staff approves or denies the AT request when the device costs less than $5000.

(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost of $5000 or more. When authorization of an AT device of $5000 or more is requested:

(A) The AT-experienced resource development staff:

(i) Solicits three (3) AT bids; and

(ii) Submits the AT request, bids, and other relevant information identified in (1) of this subsection to the State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and

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

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

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

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

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

~~(D) The authorization of an AT device of $5000 or more is completed per (2) of this subsection, and the AT-experienced resource development staff with:~~

~~(i) Solicits three (3) AT bids;~~

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

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

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

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

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

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

(k) **Eye glasses and eye exams**. Routine eye examination or the purchase of corrective lenses for members twenty-one (21) years of age and older, not covered by SoonerCare (Medicaid), may be authorized for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment can be made to a licensed optometrist who has a current contract on file with OHCA for services within the scope of Optometric practice as defined by the appropriate State law; provided, however, that services performed by out-of-state providers are only compensable to the extent that they are covered services.

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

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

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

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

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

~~(m)~~(n) **AT device rental.** AT devices are rented when the licensed professional or AT-experienced resource development ~~staffdetermines~~staff determines rental of the device is more cost effective than purchasing the device or the licensed professional recommends a trial period to determine if the device meets the member's needs.

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

(2) AT-experienced resource development staff monitor use of equipment during the rental agreement for:

(A) Rental time frame cost effectiveness;

(B) Renewal conditions; and

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

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

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

(A) Meets the member's needs; and

(B) ~~Should~~Needs to be purchased or returned.

~~(n)~~(o) **AT committee.** The AT committee reviews equipment requests when deemed necessary by the OKDHS DDS State Office AT programs manager.

(1) The AT committee is comprised of:

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

(B) DDS State Office AT programs manager;

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

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

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

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

317:40-5-102. Nutrition ~~Services~~services

(a) **Applicability.** The rules in this Section apply to nutrition services authorized for members who receive services through Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD)~~(DDS).

(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)~~(Plan). 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~~HCBS, and a SoonerCare (Medicaid) provider agreement for nutrition services. Nutrition ~~Services~~services are provided per Oklahoma Administrative Code (OAC) 340:100-3-33.1. In order for the member to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.

(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.~~ an order for nutrition services current within one (1) year signed by a medical or osteopathic physician, physician assistant, or other licensed health care professional with prescriptive authority.

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

(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~~fifteen (15) minutes for encounter and record documentation is required.

(7) A unit is ~~15~~fifteen (15) minutes.

(8) Nutrition services are limited to ~~192~~one hundred ninety-two (192) units per Plan of Care year.

(c) **Evaluation.** When arranged by the case manager, the nutrition services contract provider evaluates the member's nutritional status and completes the Level of Nutritional Risk

Assessment.

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

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

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

(C) ~~dietary~~Dietary assessment, including:

(i) ~~nutrient~~Nutrient needs;

(ii) ~~eating~~Eating skills;

(iii) ~~nutritional~~Nutritional intake; and

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

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

(i) ~~outcomes;~~Outcomes;

(ii) ~~strategies;~~Strategies;

(iii) ~~staff~~Staff training; and

(iv) ~~program~~Program monitoring and evaluation.

(2) The nutrition services contract provider and other involved professionals make recommendations for achieving positive nutritional outcomes based on the risks identified on ~~the~~ OKDHS Form 06HM040E, Level of Nutritional Risk Assessment.

(3) The nutrition services contract provider sends a copy of the Level of Nutritional Risk Assessment to the case manager within ten (10) ~~working~~ days of receipt of the authorization.

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

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

(1) Desired nutritional outcomes are developed and integrated into the I~~ndividual~~ 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;~~Strategies;

(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~~identifies 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.

(4) Any member who receives paid ~~24~~twenty-four (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~~delineates responsibilities

to insure there is no duplication of services. The mealtime assistance plan includes but is not limited to:

(A) ~~a~~A physician ordered diet;

(B) ~~diet~~Diet instructions;

(C) ~~positioning~~Positioning needs;

(D) ~~assistive~~Assistive technology needs;

(E) ~~communication~~Communication needs;

(F) ~~eating~~Eating assistance techniques;

(G) ~~supervision~~Supervision requirements;

(H) ~~documentation~~Documentation requirements;

(I) ~~monitoring~~Monitoring requirements; and

(J) ~~training~~Training and assistance.

(5) For those members receiving paid ~~24~~twenty-four (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.

(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 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~~Plan.

(4) Program documentation is maintained in the member's home record for the purpose of evaluation and monitoring.

(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.

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

(i) ~~completeness;~~completeness;

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

(iii) ~~positive~~Positive outcomes.

(B) When a member is identified by the Level of Nutritional Risk Assessment to be at high nutritional risk, he or she receives increased monitoring by the nutrition services contract provider and health care coordinator, as determined necessary by the Team.

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

(D) The Level of Nutritional Risk Assessment:

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

(ii) ~~must~~Must be submitted by the nutrition services contract provider to the ~~DDSD~~DDS area nutrition therapist or ~~DDSD~~DDS area professional support services designee within ~~15~~fifteen (15) calendar days following the end of each quarter.

317:40-5-103. Transportation

(a) **Applicability.** The rules in this Section apply to transportation services provided through ~~the~~ Oklahoma ~~Department of~~ Human Services ~~(DHS),~~ Developmental Disabilities Services (DDS); Home and ~~Community Based~~Community-Based Services (HCBS) Waivers.

(b) **General Information.** Transportation services include adapted, non-adapted, and public transportation.

(1) Transportation services are provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills. Members are encouraged to utilize natural supports or community agencies that can provide transportation without charge before accessing transportation services.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care (POC).

(A) Adapted or non-adapted transportation may be provided for each eligible person.

(B) Public transportation may be provided up to a maximum of ~~$5,000~~$15,000 per ~~Plan of Care~~POC year. The DDS director or designee may approve requests for public transportation services totaling more than $~~5,000~~$15,000 per year when public transportation promotes the member's independence, is the most cost-effective option or only service option available for necessary transportation. For the purposes of this Section, public transportation is defined as:

(i) ~~services,~~Services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) ~~a~~A transportation program operated by the member's employment services or day services provider.

(3) Transportation services must be included in the member's Individual Plan (Plan) and arrangements for this service must be made through the member's case manager.

(4) Authorization of Transportation Services is based on:

(A) Personal Support Team (Team) consideration, per Oklahoma Administrative Code (OAC) 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the member's need, per (d) of this Section; and

(B) ~~the~~The scope of transportation services as explained in this Section.

(c) **Standards for transportation providers.** All drivers employed by contracted transportation providers must have a valid and current Oklahoma driver license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport members:

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

(B) ~~is~~Is maintained in a safe condition;

(C) ~~has~~Has a current vehicle tag; and

(D) ~~is~~Is operated ~~in accordance with~~per local, state, and federal law, regulation, and ordinance.

(2) The provider maintains liability insurance in an amount sufficient to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

(3) The provider ensures all members wear safety belts during transport.

(4) Regular vehicle maintenance and repairs are the responsibility of the transportation

provider. Providers of adapted transportation services are also responsible for maintenance and repairs of modifications made to vehicles. Providers of non-adapted transportation with a vehicle modification funded through HCBS assistive technology services may have repairs authorized per OAC 317:40-5-100.

(5) Providers must maintain documentation, fully disclosing the extent of services furnished that specifies the:

(A) ~~service~~Service date;

(B) ~~location~~Location and odometer mileage reading at the starting point and destination; or trip mileage calculation from ~~Global Positioning System (GPS)~~global positioning system software;

(C) ~~name~~Name of the member transported; and

(D) ~~purpose~~Purpose of the trip.

(6) A family member, including a family member living in the same household of an adult member may establish a contract to provide transportation services to:

(A) ~~work~~Work or employment services;

(B) ~~medical~~Medical appointments; and

(C) ~~other~~Other activities identified in the Plan as necessary to meet the needs of the member, per OAC 340:100-3-33.1.

(7) Individual transportation providers must provide verification of vehicle licensure, insurance and capacity to the DDS area office before a contract may be established and updated verification of each upon expiration. Failure to provide updated verification of a current and valid Oklahoma driver license ~~and/or~~ or vehicle licensure may result in cancellation of the contract.

(d) **Services not covered.** Services that cannot be claimed as transportation services include:

(1) ~~services~~Services not approved by the Team;

(2) ~~services~~Services not authorized by the ~~Plan of Care~~POC;

(3) ~~trips~~Trips that have no specified purpose or destination;

(4) ~~trips~~Trips for family, provider, or staff convenience;

(5) ~~transportation~~Transportation provided by the member;

(6) ~~transportation~~Transportation provided by the member's spouse;

(7) ~~transportation~~Transportation provided by the biological, step or adoptive parents of the member or legal guardian, when the member is a minor;

(8) ~~trips~~Trips when the member is not in the vehicle;

(9) ~~transportation~~Transportation claimed for more than one (1) member per vehicle at the same time or for the same miles, except public transportation;

(10) ~~transportation~~Transportation outside Oklahoma unless:

(A) ~~the~~The transportation is provided to access the nearest available medical or therapeutic service; or

(B) ~~advance~~Advance written approval is given by the DDS area manager or designee;

(11) ~~services~~Services that are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;

(12) ~~transportation~~Transportation that occurs during the performance of the member's paid employment, even when the employer is a contract provider; or

(13) ~~transportation~~Transportation when a closer appropriate location was not selected.

(e) **Assessment and Team process.** At least annually, the Team addresses the member's transportation needs. The Team determines the most appropriate means of transportation based

on the:

(1) ~~present~~Present needs of the member. When addressing the possible need for adapted transportation, the Team only considers the member's needs. The needs of other individuals living in the same household are considered separately;

(2) ~~member's~~Member's ability to access public transportation services; and

(3) ~~availability~~Availability of other transportation resources including natural supports, and community agencies.

(f) **Adapted transportation.** Adapted transportation may be transportation provided in modified vehicles with wheelchair or stretcher-safe travel systems or lifts that meet the member's medical needs that cannot be met with the use of a standard passenger vehicle, including a van when the modification to the vehicle was not funded through HCBS assistive technology service and is owned or leased by the DDS HCBS provider agency, family of an adult member, agency companion provider or specialized foster care provider.

(1) Adapted transportation is not authorized when a provider agency leases an adapted vehicle from a member or a member's family.

(2) Exceptions to receive adapted transportation services for modified vehicles other than those with ~~wheelchair/stretcher~~wheelchair or stretcher safe travel systems and lifts may be authorized by the DDS programs manager for transportation services when documentation supports the need, and there is evidence the modification costs exceeded $10,000. All other applicable requirements of OAC 317:40-5-103 must be met.

(3) Adapted transportation services do not include vehicles with modifications including, but not limited to:

(A) ~~restraint~~Restraint systems;

(B) ~~plexi-glass~~Plexi-glass windows;

(C) ~~barriers~~Barriers between the driver and the passengers;

(D) ~~turney~~Turney seats; and

(E) ~~seat~~Seat belt extenders.

(4) The Team determines if the member needs adapted transportation according to:

(A) ~~the~~The member's need for physical support when sitting;

(B) ~~the~~The member's need for physical assistance during transfers from one surface to another;

(C) ~~the~~The portability of the member's wheelchair;

(D) ~~associated~~Associated health problems the member may have; and

(E) ~~less~~Less costly alternatives to meet the need.

(5) The transportation provider and the equipment vendor ensure that the Americans with Disabilities Act requirements are met.

(6) The transportation provider ensures all staff assisting with transportation is trained according to the requirements specified by the Team and the equipment manufacturer.

(g) **Authorization of transportation services.** The limitations in this subsection include the total of all transportation units on the ~~Plan of Care~~POC, not only the units authorized for the identified residential setting.

(1) Up to 12,000 units of transportation services may be authorized in a member's ~~Plan of Care~~ POC per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(2) When there is a combination of non-adapted transportation and public transportation on a ~~Plan of Care~~POC, the total cost for transportation cannot exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate

multiplied by 12,000 miles for the ~~Plan of Care~~POC year.

(3) The DDS area manager or designee may approve:

(A) ~~up~~Up to 14,400 miles per ~~Plan of Care~~POC year for people who have extensive needs for transportation services; and

(B) ~~a~~A combination of non-adapted transportation and public transportation ~~on a Plan of Care,~~ when the total cost for transportation does not exceed the cost for non-adapted transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the ~~Plan of Care~~POC year.

(4) The DDS division director or designee may approve:

(A) ~~transportation~~Transportation services in excess of 14,400 miles per ~~Plan of Care~~POC year in extenuating situations when person-centered planning identified specific needs that require additional transportation for a limited period; or

(B) ~~any~~Any combination of public transportation services with adapted or non-adapted transportation when the total cost for transportation exceeds the cost for non-adapted transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the POC year; or

(C) ~~public~~Public transportation services in excess of ~~$5,000~~$25,000, when it promotes the member's independence, is the most cost effective or only service option available for necessary transportation.