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POLICY TRANSMITTAL NO. 09-49	DATE: SEPTEMBER 16, 2009
OKLAHOMA HEALTH CARE AUTHORITY/AGING SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-1200 through 30-5-1206; and 35-23-1 through 35-23-4.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Rules are issued to implement the Living Choice program created to promote community living for individuals with disabilities or long-term illnesses as authorized by Section 6071 of Public Law 109-171. With grant funding from the Centers for Medicare and Medicaid Services under the Money Follows the Person demonstration for a five year period, the Agency will facilitate the transition of over 2,000 individuals from institutional settings to their own homes in the community and help rebalance Oklahoma's long-term care system.

Original signed on 9-8-09

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Lance Robertson, Director  
Aging Services Division

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Sandra Harrison, Coordinator  
Office of Legislative Relations and  
Policy

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WF # 09-W (NAP)

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## **INSTRUCTIONS FOR FILING MANUAL MATERIAL**

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS as the rulemaking agency; the "2" specifies the Chapter number; and the "1" specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, OKDHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, OKDHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at 405-521-4326.

### **REMOVE**

### **INSERT**

317:30-5-1200	317:30-5-1200, pages 1-2, issued 12-1-08
317:30-5-1201	317:30-5-1201, pages 1-2, issued 12-1-08
317:30-5-1202	317:30-5-1202, pages 1-2, issued 12-1-08
317:30-5-1203	317:30-5-1203, 1 page only, issued 12-1-08
317:30-5-1204	317:30-5-1204, 1 page only, issued 12-1-08
317:30-5-1205	317:30-5-1205, 1 page only, issued 12-1-08
317:30-5-1206	317:30-5-1206, 1 page only, issued 12-1-08
317:35-23-1	317:35-23-1, 1 page only, issued 12-1-08
317:35-23-2	317:35-23-2, 1 page only, issued 12-1-08
317:35-23-3	317:35-23-3, 1 page only, issued 12-1-08
317:35-23-4	317:35-23-4, 1 page only, issued 12-1-08

**MEDICAL PROVIDERS-FEE FOR SERVICE  
LIVING CHOICE PROGRAM  
SERVICES SPECIFIC**

OAC 317:30-5-1200 p(1)

**317:30-5-1200. Benefits for members age 65 or older with disabilities or long-term illnesses**

(a) Living Choice program participants age 65 or older with disabilities or long-term illnesses may receive a range of necessary medical and home and community based services for one year after moving from an institutional setting. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.

(d) Services that may be provided through the Living Choice program for older persons with disabilities or long-term illnesses are listed in paragraphs (1) through (24) of this subsection:

- (1) case management;
- (2) respite care;
- (3) adult day health care;
- (4) environmental modifications;
- (5) specialized medical equipment and supplies;
- (6) therapy services including physical, occupational, speech and respiratory;
- (7) advanced supportive/restorative assistance;
- (8) skilled nursing;
- (9) home delivered meals;
- (10) hospice care;
- (11) medically necessary prescription drugs;
- (12) personal care as described in Part 95 of this Chapter;
- (13) Personal Emergency Response System (PERS);
- (14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
- (15) transition coordination;
- (16) community transition services as described in OAC 317:30-5-1205;
- (17) dental services (up to \$1,000 per person annually);
- (18) nutrition evaluation and education services;
- (19) agency companion services;
- (20) pharmacological evaluations;

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**OAC 317:30-5-1200 p(2)**

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- (21) vision services including eye examinations and eyeglasses;
- (22) non-emergency transportation;
- (23) family training services; and
- (24) SoonerCare compensable medical services.

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OAC 317:30-5-1201 p(1)

**317:30-5-1201. Benefits for members with mental retardation**

(a) Living Choice program participants with mental retardation may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through the Community waiver.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan. The transition plan may be amended as the member's needs change.

(d) Services that may be provided to members with mental retardation are listed in paragraphs (1) through (28) of this subsection:

- (1) assistive technology;
- (2) adult day health care;
- (3) architectural modifications;
- (4) audiology evaluation and treatment;
- (5) community transition;
- (6) daily living support;
- (7) dental services;
- (8) family counseling;
- (9) family training;
- (10) group home;
- (11) respite care;
- (12) homemaker services;
- (13) habilitation training services;
- (14) home health care;
- (15) intensive personal support;
- (16) extended duty nursing;
- (17) skilled nursing;
- (18) nutrition services;
- (19) therapy services including physical, occupational, and speech;
- (20) psychiatry services;
- (21) psychological services;
- (22) agency companion services;
- (23) non-emergency transportation;

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**OAC 317:30-5-1201 p(2)**

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- (24) pre-vocational services;
- (25) supported employment services;
- (26) specialized foster care;
- (27) specialized medical equipment and supplies; and
- (28) SoonerCare compensable medical services.

**MEDICAL PROVIDERS-FEE FOR SERVICE  
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SERVICES SPECIFIC**

OAC 317:30-5-1202 p(1)

**317:30-5-1202. Benefits for members with physical disabilities**

(a) Living Choice program participants with physical disabilities may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.

(d) Services that may be provided to members with physical disabilities are listed in paragraphs (1) through (31) of this subsection:

(1) case management;

(2) personal care services as described in Part 95 of this Chapter;

(3) respite care;

(4) adult day health care with personal care and therapy enhancements;

(5) architectural modifications;

(6) specialized medical equipment and supplies;

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) therapy services including physical, occupational, speech and respiratory;

(11) hospice care;

(12) Personal Emergency Response System (PERS);

(13) Consumer Directed Personal Assistance Services (CD-PASS);

(14) agency companion services;

(15) extended duty nursing;

(16) psychological services;

(17) audiology treatment and evaluation;

(18) non-emergency transportation;

(19) assistive technology;

(20) dental services (up to \$1,000 per person annually);

(21) vision services including eye examinations and eyeglasses;

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**OAC 317:30-5-1202 p(2)**

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- (22) pharmacotherapy management;
- (23) independent living skills training;
- (24) nutrition services;
- (25) family counseling;
- (26) family training;
- (27) transition coordination;
- (28) psychiatry services;
- (29) community transition services as described in OAC 317:30-5-1205;
- (30) pharmacological evaluations; and
- (31) SoonerCare compensable medical services.

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**OAC 317:30-5-1203**

**317:30-5-1203. Billing procedures for Living Choice services**

(a) The approved individual transition plan is the medical basis for services and includes the prior authorizations, specifying:

(1) what service;

(2) which service provider;

(3) the number of units authorized; and

(4) the authorized begin and end dates of the service.

(b) As part of Living Choice quality assurance, audits are used to evaluate whether claims are consistent with individual transition plans and services provided are documented. Claims that are not supported by individual transition plans and/or documentation of services are referred to the Surveillance Utilization Review Subsystem unit (SURS). Erroneous or invalidated claims identified through post payment reviews are recouped from the provider.

(c) Claims may not be filed until the services are rendered.



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**OAC 317:30-5-1204**

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**317:30-5-1204. Disclosure of information on health care providers  
and contractors**

In accordance with the requirements of the Social Security Act and the regulations issued by the Secretary of Health and Human Services, the OHCA is responsible for disclosure of pertinent findings resulting from surveys made to determine eligibility of certain providers for home health care and contractors under SoonerCare. The Oklahoma State Department of Health (OSDH) is responsible for surveying home health care providers and contractors to obtain information for use by the Federal Government in determining whether these entities meet the standards required for participation as Medicare and SoonerCare providers.



**MEDICAL PROVIDERS-FEE FOR SERVICE  
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**OAC 317:30-5-1205**

**317:30-5-1205. Community transition services**

(a) Community transition services are one-time set-up expenses for members who transition from a nursing facility or public ICF/MR to a home in the community.

(b) Each member who transitions into the community is eligible for up to \$2,400 per person for the purchase of essential goods and/or services authorized by a transition coordinator on the member's behalf.

(c) Community transition services must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(d) Allowable expenses for community transition services include, but are not limited to:

(1) security deposits that are required to obtain a lease on a qualified residence;

(2) essential household items required for occupation and use in a community residence such as furniture, window coverings, food preparation and bed/bath linens;

(3) connection, set-up fees or deposits for utility service or access including telephone, electricity, heating and water;

(4) services necessary for the member's health, safety and welfare such as pest eradication and one-time cleaning prior to occupancy;

(5) moving expenses;

(6) fees to obtain a copy of birth certificate, identification card or driver's license; and

(7) delivery, set-up costs and removal fees for appliances, furniture, etc.

(e) Non-allowable expenses for community transition services include, but are not limited to:

(1) monthly rental or mortgage expenses;

(2) monthly utility charges;

(3) household items that are purely for recreational purposes; and

(4) services or items that are available through other Living Choice services such as homemaker services, environmental modifications and adaptations, or specialized supplies and equipment.



**317:30-5-1206. Transition coordinator services**

Transition coordinators must meet the requirements in paragraphs (1) and (2) of this subsection.

(1) Transition coordinators must:

(A) complete case management training with the ADvantage waiver; or

(B) complete the curriculum requirements for a bachelor's degree and one year paid professional experience in aging or disability populations; or

(C) complete a degree program as a registered nurse or licensed practice nurse and one year paid professional experience; or

(D) have at least two years paid work experience as an independent living specialist or transition specialist at one of the five federally recognized Centers for Independent Living organizations in Oklahoma.

(2) Transition coordinators must successfully complete the Living Choice program transition coordinator training.



**MEDICAL ASSISTANCE FOR ADULTS  
AND CHILDREN-ELIGIBILITY**

**OAC 317:35-23-1**

**317:35-23-1. Living Choice program**

The Living Choice program is created to promote community living for members with disabilities or long-term illnesses and is authorized by Section 6071 of Public Law 109-171, the Deficit Reduction Act of 2005.



**317:35-23-2. Eligibility criteria**

(a) Adults with disabilities or long-term illnesses, members with mental retardation and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (6) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least six months prior to the proposed transition date.

(3) He/she must have at least one month of SoonerCare paid long-term care services prior to transition.

(4) He/she requires at least the same level of care that necessitated admission to the institution.

(5) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(6) His/her needs can be met by the Living Choice program while living in the community.



**317:35-23-3. Participant disenrollment**

- (a) Members are disenrolled from the program if he/she:
- (1) is admitted to a nursing facility, ICF/MR, residential care facility or behavioral health facility for more than 30 consecutive days;
  - (2) is incarcerated;
  - (3) is determined to no longer meet SoonerCare financial eligibility for home and community based services;
  - (4) determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or
  - (5) moves out of state.
- (b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.



**317:35-23-4. Re-enrollment**

(a) A member may re-enroll in the program without residing in an institution for the six months prior if:

(1) the necessity for the institutionalization is documented in the revised individual transition plan; and

(2) the member can safely return to the community as determined by the transition coordinator, the member and the transition planning team.

(b) The member remains eligible during hospitalization and convalescent care periods as long as the stay does not exceed six months.