Ohio | Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

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Regulation/Package Title (a general description of the rules' substantive content): HCBS Policy Unwinding PHE (BIA)

Rule Number(s): 5160-44-11 new, 5160-44-11 rescind, 5160-44-12, 5160-44-13 new, 5160-44-13 rescind, 5160-44-14, 5160-44-16, 5160-44-17, 5160-44-22, 5160-44-26, 5160-44-27, 5160-44-31 and 5160-46-04

Included for Informational Purposes Only: 5160-44-01, 5160-45-01 and 5160-45-03

Date of Submission for CSI Review: 7/24/2023

Public Comment Period End Date: 7/31/2023

Rule Type/Number of Rules:

New/_2__ rules
Amended/__9 rules (FYR? Yes___)
No Change/____ rules (FYR? ___)
Rescinded/__2__ rules (FYR? _Yes__)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   5160-44-11, 5160-44-12, 5160-44-13, 5160-44-14, 5160-44-16, 5160-44-17, 5160-44-22, 5160-44-26, 5160-44-27, 5160-44-31, and 5160-46-04.

b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   5160-44-12, 5160-44-13, 5160-44-14, 5160-44-16, 5160-44-17, 5160-44-22, 5160-44-27, 5160-44-31, and 5160-46-04.

d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   In preparation for the expiration of the Appendix K authorities, ODM is proposing amendments to the following OAC rules:

   Rule 5160-44-11, entitled "Nursing facility-based level of care home and community-based services programs: home delivered meals," sets forth the definitions, service description, meal specifications (menu and delivery), limitations and provider qualifications for the home delivered meals service.

   - Better defined billable meal types (standard, kosher and therapeutic)
   - Added flexibility to enable an individual to select reduced calorie, reduced sugar, reduced sodium, gluten-free, and vegetarian diet meals due to personal preference.

- Removed the use of the term special diet.
- Reformatted person-centered plan element description.
- Removed provider deeming language.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.
- Per the LSC guidelines, the rule is being filed as rescind/new as more than fifty percent of the rule is being amended with the addition and rescission of text.

Rule 5160-44-12, entitled "Nursing facility-based level of care home and community-based services programs: home maintenance and chore," sets forth the definitions of services, provider requirements and specifications for the home maintenance and chore services.

- Added environmental hazards, warranty and maintenance plan for adaptive assistive devices and home modifications to be allowable through the service.
- Added allowance for service to be combined with other waiver services to meet the assessed needs of the individuals (a combination of services may be authorized to complete a job).
- Removed provider deeming language.
- Per CMS direction, removed allowance for the service to be accessed 180 days prior to an individual's transition from an institutional setting into the community.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

Rule 5160-44-13, entitled "Nursing facility-based level of care home and community-based services programs: home modification," sets forth the service description, authorization process and amount, service limitations and provider requirements for home modification services.

- Added allowance for service to be combined with other waiver services to meet the assessed needs of the individuals (a combination of services may be authorized to complete a job).
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.
- Per the LSC guidelines, the rule is being filed as rescind/new as more than fifty percent of the rule is being amended with the addition and rescission of text.

Rule 5160-44-14, entitled "Nursing facility-based level of care home and community-based services programs: community integration," sets forth the definitions of services, provider requirements and specifications for community integration services.

- Decreased years of experience requirements of supervisor.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

Rule 5160-44-16, entitled "Nursing facility-based level of care home and community-based services programs: personal emergency response systems," sets forth the service description, equipment specifications, personal emergency response systems (PERS) limitations, and PERS provider requirements.

- Removed deeming language.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

Rule 5160-44-17, entitled "Nursing facility-based level of care home and community-based services programs: out-of-home respite," sets forth the service description, provider qualifications and clinical record keeping requirements for the nursing facility-based home and community services waiver out-of-home respite service.

- Removed deeming language.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

Rule 5160-44-22, entitled "Nursing facility-based level of care home and community-based services programs: waiver nursing services," sets forth the service description, limitations, provider qualifications and requirements, and clinical record keeping requirements for waiver nursing services.

- Removed restrictive language.
- Reinstated requirement for waiver nursing to not be used in lieu of similar services.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Added requirement for RN assessment to be billed using state plan nursing assessment code.
- Removed deeming language.
- Language permitting spouse and relatives appointed legal decision making authority to serve as direct care workers of certain waiver services.

Rule 5160-44-26, entitled "Nursing facility-based level of care home and community-based services programs: community transition," sets forth the definitions of services, provider requirements and specifications for community transition services.

- Removed deeming language.
- Broadened examples of allowable basic household expenses.
- Added CMS requirement language stating the service does not include furnishing arrangements that are owned or leased by a waiver provider where the provision of these items are inherent to the service they are already providing.
- Removed the flexibility allowing signature to be obtained at a later date.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

Rule 5160-44-27, entitled "Nursing facility-based level of care home and community-based services programs: home care attendant services," sets forth the definitions related to the rule, service description, individual expectations, provider qualifications and requirements, and clinical record keeping requirements.

- Removed the requirement for continuing education hours.
- Removed temporary flexibility allowing CPR and First Aide to be obtained solely through internet training.
- Modified record keeping to eliminate the requirement for the clinical record to be stored at the provider's place of business.
- Removed requirement for a separate record to be maintained in the individuals home if the clinical record is accessible in the home.
- Removed duplicative language describing group setting service authorization.
- Reinstated requirement for face-to-face RN visits.
- Modified temporary flexibilities allowing the individual's signature to be obtained at a later date.
- Removed deeming language.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

Rule 5160-44-31, entitled "Ohio department of medicaid (ODM)-administered waiver programs: provider conditions of participation," describes provider conditions of participation for services outlined in OAC Chapters 5160-44 and 5160-46. It sets forth what a service provider shall and shall not do while providing services to individuals.

- Language permitting the parent of minor children, spouse, and relatives appointed legal decision making authority to serve as direct care workers of certain waiver services.
- Modified the temporary flexibility to obtain the individual's signature for services rendered to within three business days.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

Rule 5160-46-04, entitled "Ohio home care waiver: definitions of the covered services and provider requirements and specifications," describes the definitions of services, provider requirements and specifications for the delivery of Ohio Home Care Waiver services.

- Decreased in-service continuing education requirements for non-agency personal care providers from twelve to six.
- Reinstated restriction on solely internet-based training requirements.
- Modified RN assessment in-person requirements.
- Excluded the requirement for a discharge summary in the event the individual passes away.
- Removed the temporary allowance for the service to be provided remotely or in the home of the individual.

- Added allowance for service to be combined with other waiver services to meet the assessed needs of the individuals (a combination of services may be authorized to complete a job).
- Removed deeming language.
- Removed restrictive language.
- Modified language/reformatted requirements for clarification and grammatical errors.
- Statutory citation updates.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   5162.03, 5164.02, 5166.02, 5166.30, 5166.301, 5166.302, 5166.303, 5166.304, 5166.305, 5166.306, 5166.307, 5166.308, 5166.309, 5166.3010

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes. In order for the Centers for Medicare and Medicaid Services (CMS) to approve a 1915(c) home and community-based services (HCBS) waiver, 42 C.F.R. 441.352 requires ODM to establish provider-certification requirements to safeguard the health and welfare of individuals who receive services through the program.

5. **If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements and are aligned with the CMS-approved waivers. They do not contain provisions not specifically required by the federal government.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of these regulations is to assure the health and welfare of individuals enrolled in an ODM or ODA-administered HCBS waiver as required by 42 C.F.R. 441.302(a) through the provision of services by qualified providers. The State is doing so by establishing requirements that individuals, providers and case management agencies must meet.

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   ODM and its designees monitor providers to ensure compliance for the continued health and safety of individuals receiving services from ODM-certified providers. ODM will judge the

proposed amendments to these rules to be a success when ODM and its designees find few violations against providers during structural compliance reviews or investigations of alleged incidents.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   No.

Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
If applicable, please include the date and medium by which the stakeholders were initially contacted.

   Throughout the development of the regulation, the Ohio Department of Medicaid (ODM) engaged partner agencies for their continuous review and feedback. ODM meets bi-weekly with partners at the Ohio Department of Developmental Disabilities (DODD) and Ohio Department of Aging (ODA) to discuss drafted regulations.

   To engage a wider population of providers and participants, ODM also held nine stakeholder webinars targeting Nursing Facility-Based Waiver Case Management Entities, Developmental Disability-Based Waiver Participants and Stakeholders, and MyCare Plans. These webinars were attended by over 1,000 individuals. During these webinars, ODM provided an overview of anticipated changes to flexibilities and solicited feedback.

   ODM also maintains active communication with stakeholders. ODM developed an email address specifically to receive feedback from stakeholder and waiver participants, which was catalogued and considered throughout development.

   ODM also coordinates with DODD and ODA to release regular email communications to stakeholders to provide updates and highlight upcoming activities related to the Appendix K Flexibilities. For example, on June 21st, ODM sent an email out to stakeholders with draft copies of the rule to request additional feedback for consideration.

   Additionally, ODM developed a webpage dedicated to resuming routine Medicaid eligibility operations that includes links to regular updates on activities related to Appendix K flexibilities.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

Stakeholders are of critical importance in updating policy and practice, and in assuring the health and welfare of waiver participants. The proposed rule changes will update rules and provider and case management guidance developed with stakeholder input. The Ohio Department of Aging and the Ohio Department of Developmental Disabilities have been ODM's partners throughout this process.

Rule 5160-44-11:

In April of 2023, ODM collaborated with the Common Sense Initiative office to hold a stakeholder advocacy feedback group on the topic of home delivered meals. As a result of this collaboration, ODM was able to modify this rule to add flexibility to enable an individual to select meals due to personal preference.

Rule 5160-44-12:

Since February of 2023, ODM collaborated with Ohio Association of Medical Equipment Services and the representatives of organization providers including home modification and adaptive and assistive devices waiver service providers to hold a stakeholder advocacy feedback group on the topic of home maintenance and chore.

As results of these meetings and written feedback submitted, the following changes to this rule were made:

- Added environmental hazards, warranty and maintenance plan for adaptive assistive devices and home modifications to be allowable through the service.
- Added allowance for service to be combined with other waiver services to meet the assessed needs of the individuals (a combination of services may be authorized to complete a job).

Feedback received throughout 2023 from a variety of stakeholders through informal feedback opportunities such as meetings and emails also resulted in the changes made to this rule.

Rule 5160-44-13:

Since February of 2023, ODM has collaborated with Ohio Association of Medical Equipment Services and the representatives of organization providers including home modification and adaptive and assistive devices waiver service providers to hold a stakeholder advocacy feedback group on the topic of home modifications.

As results of these meetings and written feedback submitted, the following changes to this rule were made:

- Added allowance for service to be combined with other waiver services to meet the assessed needs of the individuals (a combination of services may be authorized to complete a job).

Feedback received throughout 2023 from a variety of stakeholders through informal feedback opportunities such as meetings and emails also resulted in the changes made to this rule.

Rule 5160-44-14:

On June 27, 2023, OHCA submitted written feedback requesting ODM consider decreasing experience requirements of the supervisor, in an effort to alleviate the workforce crisis. As a result of this feedback, the rule was modified to require 2 years' experience instead of 3 years.

Rule 5160-44-22:

As a result of informal feedback received from stakeholders throughout 2023, the following changes were made to the rule:

- Modified language/reformatted requirements for clarification and grammatical errors.
- Language permitting spouse and relatives appointed legal decision making authority to serve as direct care workers of certain waiver services.

Rule 5160-44-27:

As a result of informal feedback received from stakeholders throughout 2023, the following changes were made to the rule:

- Removed the requirement for continuing education hours.
- Modified record keeping to eliminate the requirement for the clinical record to be stored at the providers place of business.
- Removed requirement for a separate record to be maintained in the individuals' home if the clinical record is accessible in the home.

Rule 5160-44-31:

On June 27, 2023, OHCA submitted written feedback requesting ODM to consider adding flexibility in the number of days to obtain an individual's signature for services

rendered. As a result of this feedback, the rule was modified to require three business days instead of one business day.

Rule 5160-46-04:

Since February of 2023, ODM collaborated with Ohio Association of Medical Equipment Services and the representatives of organization providers including home modification and adaptive and assistive devices waiver service providers to hold a stakeholder advocacy feedback group on the topic of supplemental adaptive and assistive devices.

As results of these meetings and written feedback submitted, the following changes to this rule were made:

- Decreased in-service continuing education requirements for non-agency personal care providers from twelve to six.
- Added allowance for service to be combined with other waiver services to meet the assessed needs of the individuals (a combination of services may be authorized to complete a job).

Feedback received throughout 2023 from a variety of stakeholders through informal feedback opportunities such as meetings and emails also resulted in the changes made to this rule.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

No scientific data was used to develop the rules or the measurable outcome of the rules.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives? *Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.*

No alternative regulations were considered, as this regulation needs to align with state and federal requirements. There is no regulatory alternative that would have had less of an adverse impact on businesses that would meet CMS approval.

13. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

All regulations regarding the ODM and ODA HCBS waiver programs are promulgated by ODM and ODA and implemented by ODM and ODA, their designees and providers, as appropriate.

Likewise, regulations specific to the ODM-administered waiver programs are promulgated by ODM and implemented by ODM, its designees and providers, as appropriate. Where applicable, both agencies have worked together to ensure there's no duplication among their respective regulations.

14. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    Before the proposed amendments to these rules take effect, ODM will post them on ODM's website.

    Through regular monitoring activities, ODM and its designees will monitor ODM-certified providers for compliance.

Adverse Impact to Business

15. **Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:**

    a. **Identify the scope of the impacted business community, and**

    All nursing facility based waiver service providers within the PASSPORT, Assisted Living, Ohio Home Care and MyCare Waiver Programs.

    b. **Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).**
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a representative business. Please include the source for your information/estimated impact.

    Identify:

    OAC rule 5160-44-11 requires providers of home delivered meals to obtain a food operations license or other applicable license or certificate. Providers must develop, implement and maintain evidence of a training plan for staff that includes orientation and annual continuing education. Administrative costs may be incurred due to the requirement that delivery instructions are provided to the delivery driver and when notification must be made to individuals that the meal will be delayed. Per the LSC guidelines, the rule is being filed as rescind/new as more than fifty percent of the rule is being amended with the addition and rescission of text. The amendments did not add additional adverse impact.

    OAC rule 5160-44-12 requires that home maintenance and chore service providers be an agency or non-agency provider that has been approved by ODM or certified by ODA as a Medicaid

provider of home maintenance and chore services. Home maintenance and chore service providers must submit a fixed cost proposal to perform the services submitted under a referral issued by ODM, ODA or their designee regarding an individual's service needs. The provider must also:

- Maintain and upon request, furnish proof of appropriate qualifications to perform services requiring specialized skills such as electrical, heating/ventilation and plumbing work.
- Maintain and upon request, furnish proof of licensure, insurance and bonding for services from applicable jurisdictions.
- Maintain and upon request, furnish a list of the chemicals or substances used for each proposal.
- Furnish the individual and ODM, ODA or their designee a warranty that covers the workmanship and materials involved in performing the service, as applicable.
- Provide documentation to ODM, ODA or their designee that the service was completed in accordance with the agreed upon specifications using the materials and equipment cited in the proposal.
- Provide documentation to ODM, ODA or their designee that the service was tested, is in proper working order and is usable by the individual, if applicable.

OAC rule 5160-44-13 requires home modification service providers to submit a fixed cost proposal for services. Prior to beginning a job, the provider shall obtain all permits and pre-job inspections, as well as post job inspection reports as required by law or any homeowner's association. Home modification providers must provide documentation of service completion in accordance with the agreed upon specifications, that the modification was tested and is in proper working order and that all applicable federal, state and local building codes and accessibility codes are met. Per the LSC guidelines, the rule is being filed as rescind/new as more than fifty percent of the rule is being amended with the addition and rescission of text. The amendments did not add additional adverse impact.

OAC rule 5160-44-14 requires that community integration service providers comply with the requirements necessary to become an ODM-approved provider or an ODA- certified provider.

OAC rule 5160-44-16 requires PERS providers to do the following:

- Notify each person the individual designated when activating the individual's PERS equipment and on an annual basis thereafter as part of the monthly service that, at a minimum, the individual designated the person as a responder and to provide instructions on how to respond when an alarm is signaled.
- Notify ODM, ODA or their designee of any emergency involving an individual no more than twenty-four hours after the individual sends the alarm signal.
- Notify ODM, ODA or their designee when a pattern of frequent false alarms has been established for an individual.
- Contact emergency service personnel in the event a provider receives an alarm signal, but the station cannot reach a designated responder.

OAC 5160-44-17 requires out-of-home respite service providers to be a licensed/certified intermediate care facility for individuals with intellectual disabilities, a licensed/certified nursing

facility, or another licensed setting approved by ODM or its designee. They must provide replacement coverage due to theft, property damage and/or personal injury. They must also maintain evidence of completion of twelve hours of in-service continuing education every twelve months and program-specific orientation.

OAC 5160-44-22 requires waiver nursing providers to be registered nurses or licensed practical nurses who possess a current, valid and unrestricted licensed with the Ohio Board of Nursing. Providers must also possess an active medicaid provider agreement or be employed by an entity that has an active medicaid provider agreement.

OAC 5160-44-26 requires that community transition service providers comply with the requirements necessary to become an ODM-approved provider or an ODA-certified provider. Specifically, they must be a waiver agency, non-agency, a transition coordination service provider under contract with ODM that is also an ODM-approved or ODA-certified waiver agency or non-agency provider; or an ODA-certified assisted living waiver service provider.

OAC 5160-44-27 requires home care attendant providers to submit an ODM-specified form as part of the provider application process. It also requires the provider to submit evidence of the following: successful completion of a competency evaluation and/or training program, certified vocational program and training specific to the services to be provided. The provider must also submit a written attestation of training, instruction and skills testing. Providers must complete first aid certification and CPR certification. When the home care attendant provider secures an RN, the RN must possess a current valid and unrestricted license with the Ohio board of nursing.

OAC 5160-44-31 requires providers to maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code. ODM-administered waiver service providers are required to notify ODM or its designee within 24 hours when the provider is aware of issues that may affect the individual and/or the provider's ability to render services as directed in their person-centered services plan.

OAC 5160-46-04 requires the following:

- Home health agencies must be Medicare-certified or otherwise accredited by a national accreditation body. Personal care aides must have a certificate of completion of either a competency evaluation program or training and competency evaluation program approved and conducted by the Ohio Department of Health, or the Medicare competency evaluation program for home health aides. They must also obtain and maintain first aid certification.
- Adult day health center must provide replacement coverage due to theft, property damage and/or personal injury.
- Supplemental transportation service providers must possess a valid driver's license. Additionally, they must maintain collision/liability insurance for each vehicle/driver and obtain and exhibit evidence of valid motor vehicle inspections from the Ohio Highway Patrol for all vehicles used to provide services. Nonagency drivers must possess collision/liability insurance and obtain and exhibit evidence of required motor vehicle

inspections. Drivers must also obtain and maintain a certificate of completion of a course in first aid.

Quantify:

Effective March 1, 2013, Ohio Medicaid will start collecting a non-refundable application fee when an initial application to enroll as a Medicaid provider is submitted and also at revalidation of the provider agreement. The fee applies to organizational providers only; it does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 445.460 and in OAC 5160-1-17.8(C). The fee for 2023 is $688 per application.

The fee to Ohio Medicaid will not be required if the revalidating organizational provider has paid the fee to either Medicare or another state's Medicaid provider enrollment within the past two years. However, Ohio Medicaid will require that the revalidating organizational providers submit proof of payment with their revalidation application. (See OAC 5160-1-17.8(C))

SOURCE: Provider Enrollment (medicaid.ohio.gov)

Providers who are enrolled in Medicare but have not yet established a record in PECOS may be required to submit an Initial Enrollment application to establish a record in PECOS. If the reason for the application submittal is to change the information on the existing Medicare enrollment, and is not for the purpose of adding a practice location, then the Provider is not required to pay the application fee.

Year: 2023
Amount: $688

SOURCE: Medicare Enrollment Application Information (hhs.gov)

The tuition fees that are charged for home health aide certification programs are usually between $300 and $650.

SOURCE: https://www.bizinsure.com

In Ohio, the average STNA class costs $593 and is 3 weeks long. The exam costs $104 ($78 for skills and $26 for written).

SOURCE: https://dreambound.com

The cost for a standard first aid course is $70. To obtain a 2-year certification in Adult CPR/AED/First Aid through the American Red Cross, there is a one day workshop. For this workshop, the total tuition and fees of $90 includes the cost of your certification fees.

SOURCE: American Red Cross

To be considered for a license to provide skilled or non-medical home health service as a home health agency or nonagency provider, you must submit a completed application and a non-refundable application fee of $250.00.

Fingerprints

In accordance with Chapter 3740 of the Ohio Revised Code, the primary owner of a home health agency seeking to obtain a Non-Medical Home Health Services home health agency license is required to provide to the Ohio Department of Health their fingerprint impression card, not a criminal record check. You can find a location that provides fingerprinting services on the Ohio Attorney General's Office website. You will need to contact the location to ensure that the location can provide you with a copy of your fingerprint impressions that are either inked or done electronically. The other option is to reach out to your local law enforcement agency to see if they may be able to provide you with a fingerprint impression card.

SOURCE: Home Health Agency Licensure (Ohio Department of Health)

Several of the rules contain the requirement for a provider to report changes that may impact their ability to meet timelines or the health and safety of the individual. Such reporting may be fulfilled through email communications or other case management reporting systems.

The amount the waiver programs pay providers for a service is an all-inclusive rate. It's intended to cover the daily costs incurred in the service plus employee-related costs. The costs incurred as a result of these rules are likely calculated as part of a provider's operational budget—the cost of doing business and clerical jobs, such as retaining records, and updating policies and procedures.

16. **Are there any proposed changes to the rules that will reduce a regulatory burden imposed on the business community? Please identify.** ***(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).***

In Rule 5160-44-14, requirements for supervisors of community integration to possess at least 3 years of employment experience were reduced to 2 years.

In Rule 5160-44-27, requirements for continuing education hours for home care attendant providers were removed.

In Rule 5160-44-37, requirements for the clinical record to be stored at the providers place of business and requirements for a separate record to be maintained in the individuals' home if the clinical record is accessible in the home were both removed.

In Rule 5160-46-04, requirements for continuing education hours for non-agency personal care providers were reduced from 12 hours to 6 hours. In this rule, requirements for a discharge summary to be completed in the event the individual passes away was excluded.

Also, throughout the entire rule package, ODM identified areas providers frequently seek technical assistance to understand. As a result of this, modifications were made to rules to better clarify requirements. This should decrease the administrative burden for providers.

17. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

The assurance of HCBS waiver participants' health and welfare is integral to the Ohio HCBS waiver programs- both at the state and federal levels. Provider participation in this waiver is optional and at the provider's discretion. Compliance with program requirements is required for providers who choose to participate and may result in administrative costs associated with compliance with the requirements of these rules (e.g., training, monitoring and oversight, etc.). Failure to comply with such requirements may result in a provider's inability to be an Ohio HCBS waiver service provider.

Regulatory Flexibility

18. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

The primary purpose of these rules is to ensure the health and safety of individuals enrolled in ODA-administered programs, the rules treat all providers the same, regardless of their size.

19. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

ODM's primary concern is the health and safety of individuals receiving services from ODM-certified providers. Whenever possible, ODM or its designees will treat administrative violations that do not involve health and safety as opportunities for improvement through warning notices and solicitation of corrective action.

20. **What resources are available to assist small businesses with compliance of the regulation?**

ODM and its designees are available to help providers of all sizes with their questions. Providers may contact the Ohio Department of Medicaid (ODM) provider hotline at 1-800-686-1516.

5160-44-01 **Nursing facility-based level of care home and community-based services programs: home and community-based settings.**

(A) Notwithstanding any provisions to the contrary in paragraph (E) of this rule, individuals receiving home and community-based services (HCBS) through either an Ohio department of medicaid (ODM) or Ohio department of aging (ODA) -administered waiver program authorized under section 1915(c) of the Social Security Act (as in effect on January 1, ~~2021~~2023) or the Ohio medicaid state plan authorized under section 1915(i) of the Social Security Act (as in effect on January 1, ~~2021~~2023) ~~must~~ have to reside in and/or receive HCBS in a private residence or another setting that meets the home and community-based setting requirements set forth in this rule.

(1) A private residence is presumed to be a home and community-based setting provided it meets the requirements set forth in paragraph (B) of this rule. For the purposes of this rule, provider owned or controlled settings are not private residences.

(2) Home and community-based settings do not include any of the following:

(a) A nursing facility;

(b) An institution for mental diseases;

(c) An intermediate care facility for individuals with intellectual disabilities;

(d) A hospital; or

(e) Any other locations as determined by the ODM or its designee.

(B) Home and community-based settings ~~must~~ will have all of the following characteristics, and such other characteristics as the secretary of the U.S. department of health and human services determines to be appropriate, based on the needs of the individual as indicated in their person-centered services plan:

(1) The setting is integrated in and supports full access of individuals receiving medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving services through the ODM or ODA-administered waiver programs authorized under section 1915(c) of the Social Security Act (as in effect on January 1, ~~2021~~2023) or Ohio medicaid

state plan authorized under section 1915(i) of the Social Security Act (as in effect on January 1, ~~2021~~2023).

(2) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting.

(a) The setting options are identified and documented in the person-centered services plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board.

(b) For the purposes of this rule, non-disability specific setting means a home and community-based setting that is not limited to same or similar types of disabilities, or any disabilities at all.

(3) The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(4) The setting optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

(5) The setting facilitates individual choice regarding services and supports, and who provides them.

(C) In addition to the characteristics set forth in paragraph (B) of this rule, in a provider-owned or controlled residential setting, the following additional conditions ~~must~~ will be met, consistent with the individual's ~~approved~~ person-centered services plan.

(1) The individual's unit or dwelling is a specific physical place that can be rented or occupied under either:

(a) A legally enforceable agreement between the individual receiving services, and the owner of the dwelling pursuant to Chapter 5321. of the Revised Code.

(b) For settings in which Chapter 5321. of the Revised Code does not apply, a lease, residency agreement or other legally enforceable agreement in effect for the individual which provides protections that address eviction processes and appeals comparable to those provided under Chapter 5321. and Chapter 1923. of the Revised Code. The agreement ~~must~~will:

(i) Specify the responsibilities of the individual and the home and community-based setting;

(ii) Specify the circumstances under which the individual would be required to relocate, resulting in the termination of the agreement;

(iii) Address the steps an individual ~~must~~ will follow in order to request a review and/or appeal of the ~~relocation~~transfer or discharge from the setting that results in termination of the agreement; and

(iv) Permit the additional conditions set forth in paragraphs (C)(2) to (C)(5) of this rule unless modified in the individual's person-centered services plan.

(2) The individual has privacy in ~~his or her~~ their sleeping or living unit including all of the following:

(a) The ~~setting and~~ unit ~~have~~ has entrance doors lockable by the individual, with only appropriate staff having keys; and

(b) An individual sharing a unit has a choice of roommates in that setting.

(3) The individual has the freedom to furnish and decorate ~~his or her~~their sleeping or living unit within the lease or legally enforceable agreement.

(4) The individual has the freedom and support to control ~~his or her~~their own schedule and activities, and has access to food at any time.

(5) The individual is able to have visitors of their choosing at any time.

~~(5)~~(6) The setting is physically accessible to the individual.

(D) Any modification of the additional conditions set forth in paragraphs (C)(1) to (C)(~~5~~6) of this rule ~~must~~ will be supported by a specific assessed need and justified in the individual's person-centered services plan in accordance with rule 5160-44-02 of the Administrative Code. ~~The condition in paragraph (C)(5) of this rule cannot be modified in any way.~~

~~(E) Services provided under the 1915(c) HCBS waiver program or the 1915(i) HCBS state plan benefit may be provided in settings that have not been determined to meet the home and community-based settings criteria set forth in this rule to accommodate circumstances in which an individual requires relocation to an alternative setting to ensure the continuation of needed home and community-based services. Case managers should document what criteria were not met and what steps were taken to mitigate the deficiencies.~~

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	07/01/2016, 06/12/2020 (Emer.), 10/17/2020, 12/30/2021

5160-44-11 **Nursing facility-based level of care home and community-based services programs: home delivered meals.**

(A) The following definitions are applicable to this rule:

(1) "Dietitian" and "licensed dietitian" mean a person with a current, valid license to practice dietetics under section 4759.06 of the Revised Code.

(2) "Home delivered meals" is a meal delivery service based on an individual's need for assistance with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary needs or specialized nutritional needs, including kosher meals. The type of home delivered meals are the following

(a) Standard meal means a meal that adheres to the version of the "Dietary Guidelines for Americans" in effect on the delivery day and at least thirty-three per cent of the individual's dietary reference intakes. A standard meal may include, but is not limited to, a reduced calorie meal, reduced sodium meal, reduced sugar meal, a gluten-free meal, or vegetarian meal, if the individual chooses the meal by personal preference.

(b) Kosher meal is a meal that complies with the kosher practices for meal preparation and dietary restrictions and certified as kosher by a recognized kosher certification or a kosher establishment under orthodox rabbinic supervision.

(c) Therapeutic meal means a meal provided in accordance to an order by a licensed healthcare professional whose scope of practice includes ordering therapeutic diets:

(i) As part of the treatment for a disease or clinical condition;

(ii) To modify, eliminate, decrease or increase certain substances in the diet; or

(iii) To provide mechanically altered food when indicated.

(3) "Meals" are single portions that are ready to eat, frozen, vacuum-packed, modified-atmosphere-packed, or shelf-stable. Meals have all the following characteristics:

(a) It includes instructions on how to safely maintain, heat, reheat and/or assemble the meal, in a manner understandable to the individual and/or their caregiver.

(b) It adheres to the individual's medical restrictions as set forth in their person-centered services plan.

(B) Meal specifications.

(1) Meal menus will be approved in writing by a dietitian who is currently registered with the commission on dietetic registration, and who is also a licensed dietitian in the state in which the dietitian is located if that state licenses dietitians.

(a) Providers will furnish each individual with home delivered meals that accommodate the individual's religious, cultural, ethnic, and dietary preferences.

(b) Providers shall publish their current menu and ingredient information on their websites and offer written menus and ingredient information to individuals.

(2) An individual's person-centered services plan establishes meal delivery parameters which include all the following:

(a) Up to two meals per day. The maximum number of meals delivered will not exceed fourteen meals at one time.

(b) The type of meal.

(c) The frequency of delivery.

(d) The delivery-verification method which will include:

(i) Signature upon delivery by the individual or the individual's designee; or

(ii) The delivery driver's confirmation that delivery occurred. The provider may use an electronic system to verify.

(A) If a provider uses a common carrier to deliver meals, the provider will verify the success of the delivery by using the method in paragraph (B)(4)(d) of this rule; or

(B) By retaining the common carrier's tracking statement or other evidence showing successful delivery.

(e) A provider may deliver specifically identified items that are packaged in larger than single servings.

(3) Additional back up meals may be authorized at the discretion of the Ohio department of medicaid (ODM), the Ohio department of aging (ODA), or their designee.

(C) Meals will not be:

(1) Processed, pre-packed and commercially available to the general public for purchase; or

(2) Provided in order to supplant or replace the purchase of food or groceries for others.

(D) Provider qualifications.

(1) A provider of home delivered meals will maintain evidence of:

(a) A current, valid food operations or other applicable license or certificate as required by licensing or regulatory agencies where the meal is produced.

(b) Good standing with all applicable federal, state and local regulatory agencies; and

(c) Meeting applicable licensing requirements for safety, storage, sanitation and other applicable provisions for food service.

(2) The provider will develop, implement and maintain evidence of a training plan that includes orientation and annual continuing education.

(a) The provider will ensure anyone who participates in meal preparation, handling or delivery receives orientation on topics relevant to the person's job duties before they perform those duties.

(b) The provider will ensure anyone who participates in meal preparation, handling or delivery completes continuing education annually on topics relevant to the person's job duties.

(E) Delivery requirements.

(1) Delivery will be based on a routine delivery date and range of time.

(2) The provider will notify the individual if meal delivery will be delayed or will not occur as planned.

(3) The provider will ensure that delivery provided by commercial or common carrier meets applicable federal, state and local food safety, storage and sanitation requirements.

(F) The provider will maintain the following documentation:

(1) Initial and subsequent person-centered services plans for each individual;

(2) All diet orders;

(3) Documentation of meal delivery, including:

(a) The individual's name;

(b) The date, time and number of meals in the delivery;

(c) Verification of delivery in accordance with the individual's person-centered services plan;

(d) Verification that the individual was notified if service delivery was not provided within the established delivery date or time; and

(e) Verification that the individual has been furnished clear instructions about how to safely heat, reheat and assemble each meal.

(4) A written record, including date and topics covered, during the completion of orientation and continuing education sessions;

(5) All licensure or certification documents required by this rule;

(6) All local licensing or regulatory agency inspection reports and documented findings, any resulting plans of correction and any follow up reports; and

(7) All United States department of agriculture inspection reports and documented findings, any resulting plans of correction and any follow-up reports.

(G) The provider will replace any item lost or stolen between the time of delivery and non-receipt by the individual at no cost to the individual, ODM, ODA, or their designee.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02

TO BE RESCINDED

5160-44-11 **Nursing facility-based level of care home and community-based services programs: home delivered meals.**

(A) The following definitions are applicable to this rule:

(1) "Dietitian" and "licensed dietitian" mean a person with a current, valid license to practice dietetics under section 4759.06 of the Revised Code.

(2) "Home delivered meals" is a meal delivery service based on an individual's need for assistance with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary needs or specialized nutritional needs, including kosher meals, as ordered by a licensed healthcare professional within his or her scope of practice.

(3) "Special diet" means a diet ordered by a licensed healthcare professional whose scope of practice includes ordering special diets based upon, and adjusted to, the individual's assessed needs. A special diet is limited to:

(a) Nutrient adjusted diets, including high protein, no added salt and no concentrated sweets;

(b) Volume adjusted diets, including small, medium and large portions;

(c) The use of finger foods or bite-sized pieces for an individual's physical needs; or

(d) Mechanically altered food (i.e., the texture of food is altered by chopping, grinding, mashing or pureeing so that it can be successfully chewed and safely swallowed).

(4) "Therapeutic diet" means a diet ordered by a licensed healthcare professional whose scope of practice includes ordering therapeutic diets, including:

(a) As part of the treatment for a disease or clinical condition;

(b) To modify, eliminate, decrease or increase certain substances in the diet; or.

(c) To provide mechanically altered food when indicated.

(B) Meal specifications.

(1) Meals are single portions that are:

(a) Ready to eat; or

(b) Frozen, vacuum-packed, modified-atmosphere-packed or shelf-stable.

(2) Each meal shall:

(a) Include clear instructions on how to safely maintain, heat, reheat and/or assemble the meal.

(b) Adhere to the current "Dietary Guidelines for Americans" (www.health.gov/dietaryguidelines/).

(c) Provide at least thirty-three per cent of the dietary reference intakes;

(d) Meet state and local food safety and sanitation requirements; and

(e) Adhere to the individual's medical restrictions as set forth in their person-centered services plan.

(3) Meal menus shall be approved in writing by a dietitian who is currently registered with the commission on dietetic registration, and who is also a licensed dietitian when the state in which the dietitian is located licenses dietitians.

(a) Providers shall furnish each individual with home delivered meals that, as much as possible, accommodate the individual's religious, cultural, ethnic, and dietary preferences, including kosher meals.

(b) Providers shall publish their current menu and ingredient information on their websites and offer written menus and ingredient information to individuals.

(4) Meal delivery shall be specified in the person-centered services plan. The plan shall include the type and amount of meals to be furnished, as well as the frequency.

(a) Up to two meals per day may be provided.

(b) Planned multiple meal delivery shall not exceed fourteen meals that are compliant with food storage and safety requirements.

(c) For the purposes of this rule, method of delivery verification shall include:

(i) The individual's, his or her authorized representative's or other designee's signature upon delivery; or

(ii) The delivery driver's attestation that delivery occurred. Nothing shall prohibit the provider from using an electronic system to verify delivery.

(d) If a provider uses a common carrier to deliver meals, the provider shall verify the success of the delivery by using the method in paragraph (B)(4)(c) of this rule or by retaining the common carrier's tracking statement or returned postage-paid delivery invoice.

(e) The provider shall replace any item lost or stolen between the time of delivery and receipt by the individual at no cost to the individual, the Ohio department of medicaid (ODM), the Ohio department of aging (ODA) or their designee.

(5) Additional back up meals may be authorized at the discretion of ODM, ODA or their designee.

(C) Limitations.

(1) Meals shall not be:

(a) Processed, frozen, pre-packed and commercially available to the general public for purchase; or

(b) Provided in order to supplant or replace the purchase of food or groceries for others.

(2) A provider may deliver specifically identified items that are packaged in larger than single servings, in compliance with paragraph (B)(4) of this rule.

(3) The type of meal and frequency of delivery shall not be for provider convenience.

(D) Provider qualifications.

(1) A provider of home delivered meals shall provide and maintain evidence of:

(a) A current, valid food operations or other applicable license or certificate as required by licensing or regulatory agencies where the meal is produced.

(b) Good standing with all applicable federal, state and local regulatory agencies; and

(c) Meeting licensing requirements for safety, storage, sanitation and other applicable provisions for food service.

(2) The provider shall develop, implement and maintain evidence of a training plan that includes orientation and annual continuing education.

(a) The provider shall ensure anyone who participates in meal preparation, handling or delivery receives orientation on topics relevant to the person's job duties before they perform those duties.

(b) The provider shall ensure anyone who participates in meal preparation, handling or delivery completes continuing education annually on topics relevant to the person's job duties.

(E) Delivery requirements.

(1) Delivery shall be based on a routine delivery date and range of time.

(2) Written or electronic delivery instructions shall be provided to the delivery driver.

(3) The provider shall notify the individual if meal delivery will be delayed or will not occur as planned.

(4) The provider shall ensure that delivery provided by commercial or common carrier meets applicable federal, state and local food safety, storage and sanitation requirements.

(F) Documentation requirements.

(1) The provider shall maintain a clinical record for each individual served that shall include:

(a) Initial and all subsequent person-centered services plans;

(b) All dietary orders (including therapeutic and/or special diets) and instructions prepared by the applicable medical professional; and

(c) A record of the established delivery date and time.

(2) The provider shall maintain documentation of meal delivery, including:

(a) The individual's name;

(b) The date, time and number of meals in the delivery;

(c) Verification of delivery in accordance with the individual's person-centered services plan;

(d) Verification that the individual was notified if service delivery was not provided within the established delivery date or time; and

(e) Verification that the individual has been furnished clear instructions about how to safely heat, reheat and assemble each meal.

(3) The provider shall document and retain a written record of completed orientation and continuing education including the topics covered during the orientation and continuing education.

(4) The provider shall maintain documentation of the following:

(a) All licensure or certification documents required by this rule;

(b) All local licensing or regulatory agency inspection reports and documented findings, any resulting plans of correction and any follow up reports; and

(c) All United States department of agriculture inspection reports and documented findings, any resulting plans of correction and any follow-up reports.

(G) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02
Prior Effective Dates:	03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 07/01/1998, 07/01/2006, 10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019, 06/12/2020 (Emer.), 12/10/2020

5160-44-12 **Nursing facility-based level of care home and community-based services programs: home maintenance and chore~~services~~.**

(A) "Home maintenance and chore ~~services~~" means a service that maintains a clean and safe living environment through the performance of tasks in the individual's home that are beyond the individual's capability. Home maintenance and chore services shall not exceed a total of ten thousand dollars in a calendar year per individual. Covered home maintenance and ~~chore services~~ chore activities include:

(1) Minor home maintenance and repair including inspecting, maintaining, and repairing furnaces, including pilot lights and filters; inspecting, maintaining, and repairing water faucets, drains, heaters, and pumps; replacing or installing electrical fuses; plumbing and electrical repairs; repair or replacement of screens or window panes; fixing floor surfaces posing a threat to the individual's health, safety, and welfare; and moving heavy items to provide safe ingress and egress.

(2) Heavy household cleaning, including washing walls and ceilings; washing the outside of windows; non-routine washing of windows; removing, cleaning and rehanging curtains or drapery; and shampooing carpets or furniture.

(3) ~~Non-routine disposal of garbage~~ Removal of environmental hazards posing a threat to the individual's health, safety, and welfare~~.~~ such as:

(a) Non-routine disposal of garbage or other accumulated items in an individual’s residence;

(b) Non-routine yard maintenance including snow removal;

(c) Pest control and related tasks to prevent, suppress, eradicate, or remove pests; and

(d) Mold eradication.

(4) ~~Non-routine yard maintenance including snow removal posing a threat to the individual's health, safety, and welfare.~~Upkeep and maintenance of a home modification or adaptive/assistive devices, such as:

(a) Routine maintenance plan;

(b) Extended warranty; and

(c) Service call, labor and parts for a modification or device that ceases to function as intended.

~~(5) Pest control and related tasks to prevent, suppress, eradicate, or remove pests posing a threat to the individual's health, safety, and welfare.~~

(B) Home maintenance and chore ~~services~~ do not include:

(1) Tasks of general utility (including routine yardwork), and not of direct medical or remedial benefit to the individual.

(2) Jobs that add to the total square footage of the home.

(3) Jobs that can be accomplished through existing informal or formal supports.

(4) Jobs that are the legal or contractual responsibility of someone other than the individual (e.g., the landlord, etc.).

(5) Jobs involving the removal of home modifications and returning of property to its prior condition when the individual vacates the premises.

(6) Replacement or repair of a previously approved home modification or home maintenance and chore job that has been damaged as a result of apparent misuse, abuse, or negligence.

~~(C) Home maintenance and chore services may be authorized up to one hundred eighty consecutive days prior to an individual's transition from an institutional setting into the community. The service is not considered complete until, and the date of service for purposes of reimbursement shall be, the date on which the individual leaves the institutional setting. If an individual fails to transition into the community, the service is still reimbursable if all other requirements are met.~~

~~(D)~~(C) Home maintenance and chore ~~services~~ that are necessary to ensure the health, safety, and welfare of the individual and will exceed the ten-thousand-dollar calendar year threshold may be considered for approval by the Ohio department of medicaid (ODM), Ohio department of aging (ODA) or their designee.

~~(E)~~(D) Authorization process.

(1) ODM, ODA, or their designee may require the completion of an in-home evaluation by an appropriately qualified professional to determine the suitability of the immediate environment where the service will be performed and the viability of the completion of the service to improve independence and/or facilitate a healthy and safe environment.

(2) In consultation with the individual and/or caregiver(s), ODM, ODA, or their designee, and if ~~required~~necessary, the qualified professional, ~~shall~~ will develop a referral that addresses the individual's home maintenance and chore ~~service~~ needs.

(3) Home maintenance and chore ~~service~~ providers ~~shall~~ will submit a fixed cost proposal for the services ~~submitted~~ described under the referral which ~~shall~~ will be good for the term of the proposal.

(a) At a minimum, the proposal ~~shall~~ will include all of the following:

(i) A breakdown of all the needed materials;

(ii) A breakdown of the costs of all the needed materials;

(iii) A breakdown of the labor costs;

(iv) A list of ~~all~~ any permits that must be obtained;

(v) An estimate of the time needed to complete the service;

(vi) A written statement of all warranties provided, including a warranty lasting at least one year from the date of final acceptance of work against defective workmanship, as applicable; and

(vii) A written guarantee that all materials, products, and installed or furnished appliances perform their advertised function.

(b) A fixed cost proposal may be adjusted for good cause only if the proposal is adjusted in writing, and the adjustment is approved by ODM, ODA, or their designee.

(4) ODM, ODA, or their designee ~~shall~~ will review all submitted proposals with the individual and ~~shall~~ will approve the proposal with the lowest cost alternative that meets the individual's assessed needs and ensures the health, safety and welfare of the individual.

(5) The provider ~~shall~~ will be reimbursed for the actual cost of material and/or labor as identified in the proposal. ~~Reimbursement may only be adjusted if the fixed cost proposal is adjusted pursuant to the requirements set forth in paragraph (E)(3)(b) of this rule.~~

~~(F)~~(E) Provider requirements.

The provider ~~shall~~will:

(1) Know and understand the individual's person-centered services plan related to home maintenance and chore ~~services~~, and personal preferences regarding the specific services to be performed.

(2) Before performing a service, inform the individual and ODM, ODA, or their designee of any ~~specific~~ potential health or welfare risk, ~~expected,~~ and coordinate times and dates of service to ensure minimal risk to the individual.

~~(3) Before performing a service, obtain and maintain all permits and pre-inspections required by law, ordinance, or by the individual's homeowners' association.~~

~~(4)~~(3) Comply with applicable federal, state, and local laws, and the individual's homeowners' association (HOA) requirements, as applicable.

~~(5)~~(4) Obtain the property owner's written consent prior to performing the service. This written consent ~~shall~~ will reflect that the property owner has agreed to the maintenance, repair or other service.

~~(6) Maintain, and upon request, furnish proof of appropriate qualifications to perform services requiring specialized skills such as electrical, heating/ventilation, and plumbing work.~~

~~(7) Maintain, and upon request, furnish proof of licensure, insurance, and bonding for services from applicable jurisdictions.~~

~~(8) Maintain, and upon request, furnish a list of the chemicals and substances used for each proposal.~~

~~(9)~~(5) Furnish to the individual, ODM, ODA, or their designee a warranty that covers the workmanship and materials involved in performing the service, as applicable.

~~(10)~~(6) Provide documentation to ODM, ODA, or their designee that the service was completed in accordance with the agreed upon specifications using the materials and equipment cited in the proposal.

~~(11)~~(7) Provide documentation to ODM, ODA, or their designee that the service was tested, is in proper working order, and is usable by the individual, if applicable.

~~(12) After completing, but before billing for the service, obtain and maintain any necessary post-inspections and post-inspection reports required by law, a home~~

~~owners' association, or both to verify whether each episode of service meets federal, state, and local laws or home owners' association requirements.~~

~~(13)~~(8) Repair any damage incidental to the service at no additional cost.

~~(14) Obtain final written approval from the individual and the case manager after completion of the service.~~

(F) Home maintenance and chore may only be provided by an agency or non-agency provider approved by ODM or certified by ODA as a medicaid waiver provider of home maintenance and chore.

~~(G) Provider qualifications.~~

~~(1) Only an agency or non-agency provider that has been approved by ODM or certified by ODA as a medicaid waiver provider of home maintenance and chore service shall provide these services.~~

~~(2) Prior to performing a service, the provider shall have all necessary and required licensure in place.~~

~~(H)~~(G) Service verification: The provider ~~shall~~ will obtain the individual's or authorized representative's signature and date of completion of the service to verify service delivery, verify the provider left the individual's home in satisfactory condition, and verify repair of any damages incidental to the service.

~~(I)~~(H) Provider record retention. For each service furnished, the provider ~~shall~~ will retain a record of compliance with all requirements set forth in rule 5160-44-31 of the Administrative Code, or with the requirements set forth in Chapter 173-39 of the Administrative Code for the pre-admission screening system providing options and resources today (PASSPORT) program. The record ~~shall~~ will include:

(1) Individual's name.

(2) Date of service delivery.

(3) A copy of the fixed cost proposal described in paragraph (D)(3) of this rule, including any approved adjustments.

(4) Service description, including a comparison between the fixed cost proposal and the actual services provided.

(5) Name of each provider staff person in contact with the individual.

(6) List of chemicals and substances used.

(7) Proof of appropriate qualifications to perform services requiring specialized skills such as electrical, heating/ventilation, and plumbing work.

(8) Proof of licensure, insurance, and bonding for services from applicable jurisdictions.

(9) Proof of all necessary post-inspections and post-inspection reports required by law, a HOA, or both to verify whether each episode of service meets federal, state, and local laws or HOA requirements. Proof will be obtained prior to billing.

~~(7)~~(10) All of the documents required in paragraphs (~~F~~E), (~~G~~F), and (~~H~~G) of this rule.

(I) The authorization of home maintenance and chore may be combined with other waiver services to meet the assessed needs of the individuals. In such instances, individual waiver service limits as described in paragraph (C) of this rule still apply.

~~(J) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.~~

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	07/01/2019, 06/12/2020 (Emer.), 12/10/2020

5160-44-13 **Nursing facility-based level of care home and community-based services programs: home modification.**

(A) "Home modifications" are environmental adaptations to the private home(s) of the individual authorized by the individual's person-centered services plan, that are necessary to ensure the health, welfare and safety of the individual or that enable the individual to function with greater independence in the home. Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom or kitchen facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Home modifications also include replacement of previous home modifications when it is determined the modification cannot be repaired through another resource. Home modifications shall not exceed a total of ten thousand dollars in a calendar year per individual. The Ohio department of medicaid (ODM), Ohio department of aging (ODA) or their designee will approve the lowest cost alternative that meets the individual's assessed needs.

(B) Home modifications do not include:

(1) Adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual including, but not limited to, carpeting, roof repair and central air conditioning.

(2) Adaptations that add to the total square footage of the home, except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a home or to configure a bathroom to accommodate a wheelchair).

(3) New, replacement home modifications or repair of previously approved home modifications that have been damaged as a result of apparent misuse, abuse, or negligence.

(4) Removing modifications and returning the property to its prior condition when an individual vacates the premises

(C) Home modifications may be authorized up to one hundred and eighty consecutive days prior to an individual's transition from an institutional setting into the community.

(1) The modification is not considered complete until the individual leaves the institutional setting.

(2) The date of service for purposes of reimbursement will be the date on which the individual leaves the institutional setting. If an individual fails to transition into the community, the modification is still reimbursable.

(D) Authorization process.

(1) ODM, ODA, or their designee may require the completion of an in-home evaluation by an occupational therapist (OT) or physical therapist (PT) licensed pursuant to Chapter 4755. of the Revised Code or other appropriately qualified professional. The qualified professional conducting the evaluation will:

(a) Determine the individual's capacity to utilize the requested home modification.

(b) Determine the suitability of the immediate environment where the modification will be installed.

(c) Determine the viability of the completion of the modification to improve independence.

(d) In consultation with the individual and/or caregiver(s), develop a recommendation for a home modification to address the individual’s environmental accessibility needs.

(e) Provide ODM, ODA, or their designee with a written home modification referral that addresses the individual's environmental accessibility needs.

(2) Home modification providers will submit a fixed cost proposal for the services submitted under the home modification referral which will be good for the term of the work agreement.

(a) At a minimum, the proposal will include all of the following:

(i) A drawing or diagram of the home modification, as appropriate;

(ii) A breakdown of all of the needed materials;

(iii) A breakdown of the costs of the needed materials;

(iv) A breakdown of the labor costs;

(v) A list of all building permits that must be obtained;

(vi) An estimate of the time needed to complete the home modification;

(vii) A written statement of all warranties provided, including a warranty lasting at least one year from the date of final acceptance of work against defective workmanship; and

(viii) A written guarantee that all materials, products, and installed or furnished appliances perform their advertised function.

(b) A fixed cost proposal may be adjusted for good cause only if the job specifications are modified in writing, and the adjustment is approved by ODM, ODA or their designee.

(3) ODM, ODA or their designee will review all submitted proposals with the individual and will award the home modification service to the provider that proposes the lowest cost alternative that meets the individual's assessed need.

(E) Limitations.

(1) ODM, ODA, or their designee will ensure safeguards are in place to minimize any potential conflicts of interest between the person(s) conducting any evaluations required pursuant to paragraph (D) of this rule and the home modification provider.

(2) The provider shall be reimbursed for the actual cost of material and labor for the home modification as identified in the home modification proposal. Reimbursement may be adjusted only if the job specifications are modified pursuant to the requirements in paragraph (D) of this rule.

(3) The provider will not be the owner of the individual's home where the modification is being performed.

(F) Provider requirements.

(1) The provider will:

(a) Know and understand information contained in the individual's person-centered services plan related to the modification and personal preferences about the home modification services to be furnished.

(b) Obtain final written approval from the individual and ODM, ODA or their designee after completion of the home modification.

(2) The provider record will include evidence the provider obtained and maintained:

(a) The written consent of the property owner to modify the property, including acknowledgment that the owner understands that the waiver is not responsible for returning the property to its prior condition.

(b) All permits required by law, including building permits, prior to commencing work on each job order.

(c) Any necessary inspections and inspection reports required by federal, state and local laws upon completion of each job to verify that the repair, modification or installation was completed. The provider will obtain these inspections, inspection reports, and permits prior to billing for the completed job.

(d) Documentation that the home modification was completed in accordance with the agreed upon specifications.

(e) Documentation that the home modification was tested, is in proper working order and is functional for use by the individual.

(f) Documentation that the home modification meets all applicable federal, state and local building codes and accessibility codes.

(g) Appropriate qualifications to perform jobs requiring specialized skills such as electrical work, heating/ventilation and plumbing to ODM, ODA or their designee upon request.

(h) Licensure, insurance, and bonding for general contracting services of applicable jurisdictions to ODM, ODA or their designee upon request.

(i) All permits and pre-job inspections required by law, home owners' association, or both.

(j) All necessary post-inspections and post-inspection reports required by law, a HOA, or both to verify whether each episode of service meets federal, state, and local laws or HOA requirements. Proof will be obtained prior to billing.

(G) The authorization of home modification services may be bundled with other waiver services to meet the assessed needs of the individuals. In such instances, individual waiver service limits as described in paragraph (A) of this rule still apply.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02
Prior Effective Dates:	03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 07/01/1998, 07/01/2006, 10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019, 06/12/2020 (Emer.), 12/10/2020

TO BE RESCINDED

5160-44-13 **Nursing facility-based level of care home and community-based services programs: home modification services.**

(A) "Home modifications" are environmental adaptations to the private residence(s) of the individual required by the individual's person-centered services plan, that are necessary to ensure the health, welfare and safety of the individual or that enable the individual to function with greater independence in the home. Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom or kitchen facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Home modifications also include replacement of previous home modifications when it is determined the modification cannot be repaired through another resource. Home modifications shall not exceed a total of ten thousand dollars in a calendar year per individual. The Ohio department of medicaid (ODM), Ohio department of aging (ODA) or their designee shall approve the lowest cost alternative that meets the individual's assessed needs.

(B) Home modifications do not include:

(1) Adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual including, but not limited to, carpeting, roof repair and central air conditioning.

(2) Adaptations that add to the total square footage of the home, except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

(3) New, replacement home modifications or repair of previously approved home modifications that have been damaged as a result of apparent misuse, abuse or negligence.

(C) Home modifications may be authorized up to one hundred and eighty consecutive days prior to an individual's transition from an institutional setting into the community. The modification is not considered complete until, and the date of services for purposes of reimbursement shall be, the date on which the individual leaves the institutional setting. If an individual fails to transition into the community, the modification is still reimbursable.

(D) Authorization process.

(1) ODM, ODA or their designee may require the completion of an in-home evaluation by an occupational therapist (OT) or physical therapist (PT) licensed pursuant to Chapter 4755. of the Revised Code. The evaluation shall determine the individual's capacity to utilize the requested home modification.

(2) ODM, ODA or their designee may require the completion of an in-home evaluation by an appropriately qualified professional to determine the suitability of the immediate environment where the modification will be installed and the viability of the completion of the modification to improve independence.

(3) In consultation with the individual and/or caregiver(s), ODM, ODA or their designee and if required, the OT or PT and/or qualified professional, shall develop a home modification referral that addresses the individual's environmental accessibility needs.

(4) Home modification providers shall submit a fixed cost proposal for the services submitted under the home modification referral which shall be good for the term of the work agreement.

(a) At a minimum, the proposal shall include all of the following:

(i) A drawing or diagram of the home modification, as appropriate;

(ii) A breakdown of all of the needed materials;

(iii) A breakdown of the costs of the needed materials;

(iv) A breakdown of the labor costs;

(v) A list of all building permits that must be obtained;

(vi) An estimate of the time needed to complete the home modification;

(vii) A written statement of all warranties provided, including a warranty lasting at least one year from the date of final acceptance of work against defective workmanship; and

(viii) A written guarantee that all materials, products, and installed or furnished appliances perform their advertised function.

(b) A fixed cost proposal may be adjusted for good cause only if the job specifications are modified in writing, and the adjustment is approved by ODM, ODA or their designee.

(5) ODM, ODA or their designee shall review all submitted proposals with the individual and shall award the home modification service to the provider that proposes the lowest cost alternative that meets the individual's assessed need.

(E) Before beginning a home modification, the provider shall obtain all permits and pre-job inspections required by law, home owners' association, or both.

(F) After completing a home modification, but before submitting a claim, the provider shall obtain post-job inspections and post-job inspection reports required by law, by a home owners' association, or both to verify the modification meets federal, state and local laws or home owners' association requirements.

(G) Limitations.

(1) ODM, ODA or their designee shall ensure safeguards are in place to minimize any potential conflicts of interest between the person(s) conducting any evaluations required pursuant to paragraphs (D)(3) and (D)(4) of this rule and the home modification provider.

(2) The provider shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the home modification proposal. Reimbursement may only be adjusted if the job specifications are modified pursuant to the requirements set forth in paragraph (D)(4)(b) of this rule.

(3) Home modifications do not include removing modifications and returning the property to its prior condition when an individual vacates the premises. The property shall be left in the modified state.

(4) The provider shall not be the owner of the individual's residence.

(H) Provider requirements.

(1) The provider shall:

(a) Know and understand the individual's person-centered services plan related to the modification and personal preferences about the home modification services to be furnished.

(b) Provide documentation that the home modification was completed in accordance with the agreed upon specifications using all materials and equipment cited in the proposal.

(c) Provide documentation that the home modification was tested, is in proper working order and is usable by the individual.

(d) Provide documentation that the home modification meets all applicable federal, state and local building codes and accessibility codes.

(e) Maintain and furnish proof of appropriate qualifications to perform jobs requiring specialized skills such as electrical work, heating/ventilation and plumbing to ODM, ODA or their designee upon request.

(f) Maintain and furnish proof of licensure, insurance and bonding for general contracting services of applicable jurisdictions to ODM, ODA or their designee upon request.

(g) Obtain final written approval from the individual and ODM, ODA or their designee after completion of the home modification service.

(2) The provider shall obtain and maintain evidence of compliance with:

(a) The written consent of the property owner to modify the property, including acknowledgment that the owner understands that the waiver is not responsible for returning the property to its prior condition.

(b) All permits required by law, including building permits, prior to commencing work on each job order.

(c) Any necessary inspections and inspection reports required by federal, state and local laws upon completion of each job to verify that the repair, modification or installation was completed. The provider must obtain these inspections, inspection reports, and permits prior to billing for the completed job.

(I) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02
Prior Effective Dates:	03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 07/01/1998, 07/01/2006, 10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019, 06/12/2020 (Emer.), 12/10/2020

5160-44-14 **Nursing facility-based level of care home and community-based services programs: community integration ~~services~~.**

(A) "Community integration" ~~services are~~means independent living assistance and community support coaching activities that are necessary to enable an individual to live independently and have access to, choice of, and an opportunity to participate in, a full range of community activities.

(B) "Independent living assistance" ~~helps~~means help for individuals to manage their households and personal affairs, self-administer medications, and retain their community living arrangements. Independent living assistance can be furnished through telephone support, in-person support or travel attendant activities, as applicable to the tasks performed. ~~Tasks~~ Activities may include:

(1) Reminding an individual to take their medications;

(2) Contacting individuals at times no other in-home services are being provided to confirm the individual is functioning safely in their home;

(3) Assisting with banking;

(4) Organizing and coordinating health records;

(5) Assisting with applications for public programs including homestead exemption, the home energy assistance program, and subsidized housing;

(6) Monitoring and replenishing needed groceries (does not include cost of groceries);

(7) Assisting with business and personal correspondence;

(8) Accompanying an individual to their medical and other appointments; and

(9) Accompanying an individual on their errands and to other activities in the community.

(C) "Community support coaching" includes providing information and training to an individual so the individual can achieve the community integration goals identified in his or her person-centered services plan. Skills training topics include:

(1) How to manage finances;

(2) How to manage an individual's own health and wellness;

(3) How to identify and access community and legal resources, and leisure, educational, and recreational activities;

(4) How to find a job;

(5) How to manage an individual's own home;

(6) How to navigate community-based transportation systems; and

(7) How to build interpersonal, social, and communication skills.

(D) Community integration ~~service~~ provider requirements.

(1) Community integration ~~services shall~~ will be furnished by Ohio department of medicaid (ODM) -approved agencies or Ohio department of aging (ODA) -certified agencies.

(2) The provider ~~shall~~ will comply with the requirements set forth in rule 5160-44-31 of the Administrative Code for an ODM-administered waiver program, or Chapter 173-39 of the Administrative Code for the pre-admission screening system providing options and resources today (PASSPORT) waiver program.

(3) The provider ~~shall~~ will develop, implement, and maintain evidence of a training plan that includes initial orientation and annual continuing education.

(a) The provider ~~shall~~ will ensure anyone who furnishes community integration ~~services~~ receives orientation on topics relevant to the person's job duties before they perform those duties.

(b) The provider ~~shall~~ will ensure anyone who furnishes community integration ~~services~~ completes a minimum of twelve hours of continuing education annually on topics relevant to the person's job duties.

(4) Community integration ~~service~~ staff ~~shall~~ will have:

(a) A high school diploma, general education diploma (GED), or a minimum of one year of relevant, supervised work experience with a public health, human services, or other community service agency.

(b) The ability to understand written activity plans (description of interventions and the dates/times the provider ~~shall~~ will provide the interventions), execute instructions, document activities provided, and the ability to perform basic mathematical operations.

(c) Experience advocating on behalf of individuals with chronic illnesses, behavioral health conditions, physical disabilities, or developmental disabilities.

(5) Supervisors of community integration ~~service~~ staff ~~shall~~ will possess at least one of the following:

(a) A current and valid license to practice in the state of Ohio as a registered nurse (RN), licensed practical nurse (LPN), licensed social worker (LSW), or licensed independent social worker (LISW);

(b) A bachelor's degree or an associate's degree in human ecology, dietetics, counseling, gerontology, social work, nursing, public health, health education, or another related field; or

(c) At least ~~three~~ two years of employment experience providing community-based social services or job coaching.

(6) Supervisory responsibilities include:

(a) Collaborating with the individual to identify, develop and document a specific activities plan, including the type of intervention(s) provided, prior to initiation of services that is consistent with the individual's approved person-centered services plan.

(b) Conducting evaluations of community integration ~~service~~ staff every ninety days to ensure staff compliance with the activities plan, and the individual's satisfaction.

(E) All providers ~~shall~~ will maintain a record at their place of business for each individual served in accordance with the requirements set forth in rule 5160-44-31 of the Administrative Code for an ODM-administered waiver program, or with the requirements set forth in Chapter 173-39 of the Administrative Code for the PASSPORT program. The record ~~shall~~ will include:

(1) The individual's name;

(2) A copy of the individual's initial, and all subsequent person-centered services plans;

(3) A copy of the individual's approved activity plan;

(4) Date(s) of service;

(5) A detailed description of each task or activity performed and the staff person who performed it; and

(6) The individual's signature to verify receipt of the service.

~~(F) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.~~

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	07/01/2019, 06/12/2020 (Emer.), 12/10/2020

5160-44-16 **Nursing facility-based level of care home and community-based services programs: personal emergency response systems.**

(A) "Personal emergency response systems" (PERS) is a service with a monitoring, reminder and/or reporting component available to support individuals' independence in the community. PERS include telecommunications equipment, a central monitoring station (station), and a medium for two-way, hands-free communication between the individual and the station. Personnel at the station respond to an individual's alarm signal via the individual's PERS equipment.

(B) "PERS equipment" ~~shall be~~ means equipment that is appropriate to meet the assessed needs of the individual as authorized on the individual's person-centered services plan and ~~shall include~~that meets all of the following characteristics:

(1) ~~Activation devices that are~~Includes an activation device that is wearable and water-resistant~~. Water resistance shall meet~~ according to a generally-accepted industry standard for water resistance to a level matching the individual's assessed needs and preferences.

(2) ~~An~~ Has an internal battery providing at least twenty-four hours of power without recharging. ~~Notification shall be sent to the station if the battery level is low.~~

(3) ~~Devices to accommodate varying~~ Accommodates the individual's needs and preferences ~~of the individual~~.

(C) "PERS" does not include:

(1) Remote video monitoring of the individual in his or her home.

(2) Systems that ~~only~~ connect the individual to only emergency service personnel.

(D) PERS provider requirements. The provider ~~shall~~will:

(1) Ensure and maintain a record of the successful completion of training on how to respond to alarm signals by each staff member whose job duties include responding to alarm signals at the station.

(2) Ensure each individual is able to choose the PERS device that meets his or her assessed needs and preferences as authorized by the individual's person-centered services plan.

(3) Install and activate the individual's PERS equipment no later than seven days after the date PERS has been authorized on the individual's person-centered services plan by the Ohio department of medicaid (ODM), the Ohio department of aging (ODA) or their designee.

(4) ~~Furnish~~ Train each individual receiving PERS with ~~training including~~the following:

(a) An initial demonstration on how to use their PERS equipment. The demonstration can be conducted by telephone or electronically, unless the individual's needs necessitate ~~a face-to-face~~an in-person visit.

(b) A successful return demonstration by the individual of all components of the PERS equipment and monthly testing.

(5) Ensure the availability of language assistance in the event the individual has limited English language proficiency.

(6) ~~Prior to activating PERS equipment, the provider shall work~~Consult with the individual and case manager before activating PERS equipment to develop an initial written response plan regarding how to proceed when an alarm is signaled within the following parameters. ~~The plan shall be updated upon the individual's request.~~

(a) The written response plan ~~shall include~~ includes a summary of the individual's information regarding medical diagnosis, treatment and preferences, as well as the contact information for the individual's designated responder.

(i) For the purpose of this rule, a designated responder is a person or organization identified in an individual's written response plan who the station contacts if the individual signals an alarm and requires assistance from the designated responder.

(ii) The provider ~~shall identify~~ identifies emergency service personnel on the written response plan ~~when~~ only if the individual does not ~~otherwise provide a designated~~designate a responder or ~~when~~ only designates one ~~designated~~ responder. ~~is provided.~~

(b) The provider ~~shall notify the~~ notifies each person the individual designated ~~responder~~ when activating the individual's PERS equipment and on an annual basis thereafter as part of the monthly service. ~~At~~ that, at a minimum, ~~notification shall include directions~~ the individual designated

the person as a responder and to provide instructions on how to respond when an alarm is signaled.

(c) ~~Upon notification that an individual's designated responder stops participating, the~~The provider consults ~~shall work~~ with the individual and ODM, ODA or their designee to identify a new designated responder in the written response plan whenever the person the individual chooses to be a designated responder refuses to participate or stops participating.

(7) ~~At no additional cost to the individual, ODM, ODA, or their designee, replace~~Replace any malfunctioning PERS equipment at no additional cost to the individual, ODM, ODA, or their designee no later than twenty-four hours after it is notified of the malfunction, or no later than twenty-four hours after the malfunction is detected through the monthly testing of equipment, unless the malfunction is due to the individual's apparent misuse, abuse, or negligence of the equipment.

(8) ~~As part of its monthly service, provide~~ Provide ongoing customer support to the individual, designated responder, ODM, ODA and its designee upon request of one or more of those parties as part of the monthly service.

(9) ~~If the provider cannot assist an individual with an assessed need, the provider shall notify ODM, ODA or their designee, in writing of the service limitations before the provider is included in the individual's person-centered services plan.~~The provider will notify ODM, ODA, or their designee, in writing, if at any time, the provider determines inability to meet the individual’s assessed needs, as identified through the individual’s person-centered services plan.

(10) Employ staff to comprise a central monitoring station located in the United States or may subcontract with another company to use a station located in the United States to provide the station component of the PERS.

(11) Maintain a primary system to receive and respond to alarm signals from individuals twenty-four hours a day, every day of the year;

(12) Maintain a secondary system to respond to all incoming alarm signals in case the primary system is unable to respond to alarm signals;

(13) Respond to each alarm signal no more than sixty seconds after it receives the alarm signal;

(14) Notify ODM, ODA or their designee of any emergency involving an individual no more than twenty-four hours after the individual sends the alarm signal;

(15) Notify ODM, ODA or their designee when a pattern of frequent false alarms has been established for an individual;

(16) Contact emergency service personnel in the event a provider receives an alarm signal, but the station cannot reach a designated responder; and

(17) ~~In the event of an emergency, remain~~ Remain in communication with the individual in the event of a personal emergency through the two-way communication feature of the PERS equipment until a designated responder or emergency service personnel arrives in the individual's home, the personal emergency subsides, or after it is determined there is no personal emergency (e.g. false alarm).

(E) PERS providers ~~shall~~ will maintain the following documentation for each individual receiving PERS:

(1) Date and time of equipment delivery and installation;

(2) A copy of the individual's initial and all subsequent written response plans;

(3) Date the individual and designated responder received initial and annual notification from the PERS provider as required by paragraph (D)(6)(b) of this rule;

(4) Date, time and results of monthly testing; and

(5) Date, time and summary of actions taken regarding service-related contacts.

~~(F) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.~~

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02
Prior Effective Dates:	03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 07/01/1998, 07/01/2006, 10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019, 06/12/2020 (Emer.), 12/10/2020

5160-44-17 **Nursing facility-based level of care home and community-based services programs: out-of-home respite ~~services~~.**

(A) "Out-of-home respite ~~services~~" are services delivered to an individual in an out-of-home setting to allow ~~respite~~ a period of rest or relief for caregivers normally providing care. The service ~~shall~~ will include an overnight stay.

(1) An out-of-home respite provider ~~shall~~ will make available the following:

(a) Waiver nursing services as set forth in rule 5160-44-22 of the Administrative Code;

(b) Personal care services as set forth in rule 5160-46-04 of the Administrative Code if the individual is enrolled on an Ohio department of medicaid (ODM) -administered waiver, or rule 173-39-02.11 of the Administrative Code if the individual is enrolled in the PASSPORT program administered by the Ohio department of aging (ODA); and

(c) Three meals per day that meet the individual's dietary requirements.

(2) All services set forth in paragraph (A)(1) of this rule delivered during the provision of out-of-home respite ~~services shall~~ will not be reimbursed as separate services.

(B) To qualify for submitting claims, providers of out-of-home respite ~~services shall~~will:

(1) Comply with all applicable rules set forth in Chapter 5160-44 of the Administrative Code, and:

(a) Chapters 5160-45, and as appropriate, either 5160-46 or 5160-58 of the Administrative Code, if the individual is enrolled on an ODM-administered waiver program; or

(b) Chapter 173-39 of the Administrative Code, if the individual is enrolled in the PASSPORT program.

(2) Be either:

(a) An intermediate care facility for individuals with an intellectual disability (ICF-IID) that has an active medicaid provider agreement in accordance with sections 5124.06 and 5124.07 of the Revised Code; or

(b) A nursing facility (NF) certified in accordance with rule 5160-3-02.3 of the Administrative Code; or

(c) Another licensed setting approved by ODM or certified by ODA.

(C) All providers of out-of-home respite ~~shall~~will:

(1) Provide for coverage of an individual's loss due to theft, property damage and/ or personal injury; and maintain a written procedure identifying the steps an individual takes to file a liability claim. Upon request, the provider ~~shall~~ will verify their coverage with ODM, ODA or their designee.

(2) Maintain evidence of non-licensed staff's completion of twelve hours of in-service training within a twelve-month period, excluding agency and program-specific orientation for every employee with in-person contact with individuals. In-service training ~~shall~~ will be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and ~~shall~~ will be completed annually thereafter.

(3) Ensure any waiver nursing services provided are within the nurse's scope of practice as set forth in rule 5160-44-22 of the Administrative Code.

(4) Provide task-based instruction to direct care staff providing personal care services as defined in rule 5160-46-04 of the Administrative Code, or rule 173-39-02.11 of the Administrative Code, as applicable.

(D) Providers of out-of-home respite ~~services shall~~ will maintain a clinical record at their place of business for each individual served in accordance with the requirements set forth in rule 5160-44-31 of the Administrative Code.

(1) Storage ~~shall~~ will protect the confidentiality of these records.

(2) Each clinical record ~~shall~~ will include the following:

(a) Identifying information, including but not limited to name, address, date of birth, gender/gender identify, race, significant phone numbers and health insurance identification numbers of the individual.

(b) Information regarding medical diagnosis (es), treatment(s) and preferences.

(c) The individual's medication profile and medication administration record, as applicable.

(d) The individual's treatment administration record, as applicable.

(e) The name and contact information for the individual's primary care physician(s).

(f) The name and current contact information for the individual's parent/ guardian/authorized representative and/or emergency contact.

(g) All known drug and food interactions, allergies and dietary needs, preferences and/or restrictions.

(h) A copy of the initial and all subsequent person-centered services plans.

(i) A copy of any advance directives including, but not limited to, a do-not-resuscitate order, or medical power of attorney, if they are provided.

(j) Documentation verifying the date of out-of-home respite service delivery, including tasks performed or not performed.

(3) If the individual is receiving waiver nursing services pursuant to paragraph (A)(1)(a) of this rule, the clinical record ~~shall~~ will also include the following;

(a) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being provided. When services are provided by a licensed practical nurse (LPN) at the direction of a registered nurse (RN), the clinical records ~~shall~~ will include documentation that the RN has reviewed the plans of care with the LPN. The plan of care ~~shall~~ will be recertified by the primary care physician at least every sixty days, or more frequently if there is a significant change in the individual's condition.

(b) Documentation of any verbal orders given by the primary care physician to the nurse. The nurse shall document, in writing, the physician's orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse shall subsequently secure documentation of the verbal orders, signed and dated by the primary care physician.

(c) All communications with the individual, case manager, RN supervisor (if one exists) primary care physician and other members of the individual's team.

~~(E) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.~~

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02
Prior Effective Dates:	03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 07/01/1998, 07/01/2006, 10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019, 06/12/2020 (Emer.), 12/10/2020

5160-44-22 **Nursing facility-based level of care home and community-based services programs: waiver nursing services.**

(A) "Waiver nursing services" are defined as nursing tasks and activities provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN.

(1) All nurses providing waiver nursing services to individuals ~~shall~~will:

(a) Possess a current, valid and unrestricted license with the Ohio board of nursing; and

(b) Possess an active medicaid provider agreement or be employed by an entity that has an active medicaid provider agreement; and

(c) Provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and agency 4723 of the Administrative Code rules adopted thereunder.

(2) Nursing tasks and activities that ~~shall~~ will only be performed by an RN include, but are not limited to, the following:

(a) Intravenous (IV) insertion, removal or discontinuation;

(b) IV medication administration;

(c) Programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous and IV (except routine doses of insulin through a programmed pump);

(d) Insertion or initiation of infusion therapies;

(e) Central line dressing changes; and

(f) Blood product administration.

(B) Limitations.

(1) Waiver nursing will not be used in lieu of similar services available through third-party insurers, community supports and available resources, including Ohio medicaid state plan services when it has been determined an individual's needs can be met by those services.

~~(1)~~(2) If the provider cannot assist an individual with an assessed need, the provider ~~shall~~ will notify ODM, ODA or their designee, in writing, of the service limitation(s) before the provider is included on the individual's person-centered services plan.

~~(2)~~(3) Waiver nursing services do not include:

(a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules adopted thereunder and to be performed by providers who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;

(b) Services that require the skills of a nurse with a psychiatric mental health nursing specialty as set forth in rule 4723-8-04 of the Administrative Code;

(c) Visits performed for the sole purpose of meeting the supervisory requirements (including any visit) set forth in 42 CFR 484 (as in effect on October 1, ~~2020~~2023);

(d) Visits performed for the sole purpose of directing LPNs pursuant to section 4723.01 of the Revised Code; or

(e) Visits performed for the sole purpose of meeting the home care attendant service RN visit requirements set forth in rule 5160-44-27 of the Administrative Code.

~~(3)~~(4) Waiver nursing services are reimbursable when sequentially, but not concurrently, performed with any other service during a visit in which the RN is furnishing billable home health, private duty nursing, RN assessment, RN consultation, and/or any other similar service that is reimbursable through the Ohio medicaid program.

(C) Waiver nursing ~~shall~~ will be delivered by one of the following:

(1) An employee or contractor of a medicare-certified or otherwise-accredited home health agency approved by ODM or certified by ODA who meets the provider requirements set forth in paragraph (D) of this rule. For the purposes of this rule, medicare-certified home health agencies and otherwise-accredited agencies ~~shall~~ will ensure they and the nurses they employ or contract with, are in compliance with 42 CFR 484. (as in effect on October 1, ~~2020~~2023).

(a) Parent of minor children, spouses, and relatives appointed legal decision-making authority may serve as direct care worker in accordance with rule 5160-44-32 of the Administrative Code.

(b) Maximum weekly direct care hours set forth in rule 5160-44-32 of the Administrative Code do not apply to the parent of a minor child.

(2) A non-agency RN waiver nursing provider approved by ODM who meets the provider requirements set forth in paragraph (D) of this rule.

(3) A non-agency LPN waiver nursing provider approved by ODM who meets the provider requirements set forth in paragraphs (D) and (E) of this rule.

(D) All waiver nursing providers ~~shall~~will:

(1) Understand and comply with all applicable rules governing the home and community-based services (HCBS) waiver(s) for which they are providing services including, but not limited to those rules set forth in Chapters 5160-44, 5160-45, 5160-46, and/or 5160-58, of the Administrative Code, as applicable, for ODM-administered HCBS waiver programs, and Chapters 173-39, 5160-31, 5160-33, and/or 5160-58 of the Administrative Code, as applicable, for ODA-administered HCBS waiver programs.

(2) ~~Be providing~~ Provide the service to either one individual, or in a group setting as defined in rule 5160-46-06 of the Administrative Code during a face-to-face nursing visit in an ODM-administered HCBS waiver program, or in a group setting as defined in rule 5160-31-07 of the Administrative Code during a face-to-face nursing visit in an ODA-administered HCBS waiver program.

(3) Complete training about individual rights and responsibilities as set forth in rule 5160-45-03 of the Administrative Code for ODM-administered HCBS waiver programs.

(4) Not be the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code, unless the legally responsible family member is employed by a medicare-certified or otherwise-accredited home health agency and the individual is enrolled on an ODM-administered waiver.

(5) Not be the individual's legally responsible family member, as that term is defined in rule 173-39-02 of the Administrative Code, when the individual is enrolled on the ODA-administered waiver.

(6) Not be the foster caregiver of the individual.

(E) Non-agency LPNs, at the direction of an RN, ~~shall~~will:

(1) Conduct a ~~face-to-face~~ visit with the directing RN at least every sixty days after the initial visit to evaluate the provision of waiver nursing services and LPN performance, and to ensure that waiver nursing services are being provided in accordance with the approved plan of care and within the LPN's scope of practice. The visit may be conducted via telehealth.; and

(2) Conduct ~~a face-to-face~~an in-person visit with the individual and the directing RN before initiating services and at least every one hundred and twenty days for the purpose of evaluating the provision of waiver nursing services, the individual's satisfaction with care delivery and LPN performance, and to ensure that waiver nursing services are being provided in accordance with the approved plan of care and within the LPN's scope of practice.

(3) When the RN performs an RN assessment visit, the RN will bill the state plan nursing assessment code set forth in appendix A to rule 5160-12-08 of the Administrative Code.

(F) All waiver nursing service providers ~~shall~~ will maintain a clinical record at their place of business for each individual served in accordance with the requirements set forth in rule 5160-44-31 of the Administrative Code.

(1) Storage ~~shall~~ will be in a manner that protects the confidentiality of these records.

(2) For the purposes of this rule, the place of business ~~shall~~ will be a location other than the individual's residence or primary location where the individual receives services.

(3) Each clinical record ~~shall~~ will include the following:

(a) Identifying information, including but not limited to, name, address, date of birth, gender, gender identity, race, ~~significant~~ phone numbers and health insurance identification numbers of the individual.

(b) Information regarding medical diagnoses, treatment and preferences.

(c) The individual's medication profile and medication administration record, as applicable.

(d) The individual's treatment administration record, as applicable.

(e) The name of and contact information for the individual's primary care physician(s).

(f) The name of and ~~current~~ contact information for the individual's parent/ guardian/authorized representative and/or emergency contact.

(g) All known drug and food interactions, allergies and dietary needs, preferences and/or restrictions.

(h) A copy of the initial and all subsequent person-centered services plans.

(i) Nurse assignments.

(j) A copy of any advance directives including, but not limited to, a do-not-resuscitate (DNR) order and/or medical power of attorney, if they are provided by the individual.

(k) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being performed. When services are performed by an LPN at the direction of an RN, the clinical record ~~shall~~ will include documentation that the RN has reviewed the plans of care with the LPN. The plan of care ~~shall~~ will be recertified by the primary care physician at least every sixty days, or more frequently if there is a significant change in the individual's condition.

(l) Documentation of any verbal orders given by the primary care physician to the nurse. The nurse ~~shall~~ will document, in writing, the physician's orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse ~~shall~~ will subsequently secure documentation of the verbal orders, signed and dated by the primary care physician.

(m) In all instances when a non-agency LPN is providing waiver nursing services, clinical notes, signed and dated by the LPN, documenting all consultations between the LPN and the directing RN, the face-to-face visits between the LPN and the directing RN, and the face-to-face visits between the LPN, the individual, and the directing RN.

(n) Clinical notes, signed and dated by the nurse, documenting the general condition of the individual, any unusual events occurring during the visit and the service tasks performed or not performed.

(o) All communications with the individual, case manager, RN supervisor if one exists, primary care physician and other members of the individual's team.

(G) All waiver nursing providers ~~shall~~ will also maintain a record at the individual's residence or primary service location in order to encourage sharing of information between caregivers and enhance person-centered care.

(1) Storage ~~shall~~ will be in a manner that protects the confidentiality of these records.

(2) The record may include a communication log, treatment record and/or medication administration record, if they exist.

(3) Documents in the record ~~shall~~ will reflect a minimum of at least the past sixty calendar days, with the individual's right to maintain more if he or she so chooses.

(4) The individual ~~shall~~ will identify the location in his or her residence or the primary service location where the record will be safely maintained.

~~(H) Face-to-face visits required by this rule may be conducted by telephone or electronically, unless the individual's needs require a face-to-face visit~~

~~(I) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.~~

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 07/01/1998, 07/01/2006, 10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019, 06/12/2020 (Emer.), 10/17/2020

5160-44-26 **Nursing facility-based level of care home and community-based services programs: community transition ~~services~~.**

(A) "Community transition ~~services~~" pays for non-recurring start-up living expenses for individuals transitioning from an institutional setting to a home and community-based services (HCBS) setting that is compliant with rule 5160-44-01 of the Administrative Code. Community transition ~~services~~:

(1) ~~Include expenses necessary to enable an individual to establish a basic household. Examples include:~~Community transition includes the following:

(a) Expenses necessary to enable an individual to establish a basic household. Examples include:

(i) Security deposits and rental fees needed to obtain a lease on an apartment or home and rental expenses required to obtain a residential lease;

(ii) Essential household items such as furnishings and moving expenses required to occupy and use a community home, including furniture needed to occupy and maintain housing, including window coverings, food preparation items, and linens;

(iii) Set-up fees and deposits for utility and service access, including telephone/cellphone, electricity, gas, garbage, and water;

(iv) Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;

(v) Pre-transition transportation necessary to secure housing and benefits, etc.;

(vi) Initial cleaning and household supplies;

(vii) Activities to arrange for and to procure other non-recurring set-up expenses; and

(viii) Essential personal hygiene and clothing items needed to transition safely.

(b) The provider's administrative cost associated with providing community transition under this rule. Such fees will be included in the authorization described in paragraph (A)(2)(b) of this rule.

~~(a) Security deposits and rental expenses required to obtain a residential lease;~~

~~(b) Basic household items required to occupy and maintain housing, including window coverings, food preparation items, and linens;~~

~~(c) Fees and deposits for utility and service access, including telephone/ cellphone, electricity, gas, garbage, and water;~~

~~(d) Moving expenses;~~

~~(e) Pre-transition transportation necessary to secure housing and benefits, etc.;~~

~~(f) Initial cleaning and household supplies;~~

~~(g) Activities to arrange for and to procure other non-recurring set-up expenses; and~~

~~(h) The provider's administrative cost associated with providing community transition services under this rule. Such fees shall be included in the authorization described in paragraph (A)(2)(b) of this rule.~~

(2) ~~Are~~ Is payable only to the extent:

(a) They are determined reasonable and necessary through the person-centered services planning process described in rule 5160-44-02 of the Administrative Code and are clearly identified in an individual's person-centered services plan; and

(b) They are authorized by the Ohio department of medicaid (ODM), the Ohio department of aging (ODA) or their designee in an individual's person-centered services plan, which ~~shall~~ will only occur if no other person, including a landlord, has a legal or contractual responsibility to fund the expense, and if family, neighbors, friends, or community resources are unavailable to fund the expense.

(3) May be authorized up to one hundred eighty consecutive days before an individual's transition from an institutional setting into an HCBS setting. The date of service for purposes of payment ~~shall be~~ is the date the individual leaves the institutional setting. If the individual fails to transition to an HCBS setting, the service is still payable if all other requirements are met.

(4) ~~Shall be~~ Is provided no later than thirty days after the date on which an individual enrolls on the waiver program.

(B) Community transition ~~services do~~ does not include:

(1) Room and board, ongoing monthly rental, or mortgage expenses;

(2) Grocery expenses;

(3) Ongoing utility or service expenses;

(4) Ongoing cable or internet expenses;

(5) Electronic and other household appliances and items intended to be used for entertainment or recreational purposes; ~~and~~

(6) Tobacco products ~~and~~ or alcohol~~.~~; and

(7) Furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

(C) Limitations.

(1) Community transition ~~services shall~~ will only be used one time per individual per waiver enrollment.

(2) Community transition ~~services shall~~ will not exceed two thousand dollars per individual per waiver program enrollment.

~~(D) The provider shall involve the individual and/or caregiver(s) in the selection of items to be purchased on the individual's behalf.~~

~~(E)~~(D) Providers ~~shall~~ will:

(1) Be either:

(a) An ODM-approved or ODA-certified waiver agency provider;

(b) An ODM-approved or ODA-certified non-agency provider;

(c) A transition coordination service provider under contract with ODM that also meets the requirements set forth in paragraph (E)(1) of this rule; or

(d) An ODA-certified assisted living ~~waiver service~~ provider.

(2) Comply with the requirements set forth in rule 5160-44-31 of the Administrative Code for an ODM-administered waiver program, or Chapter 173-39 of the Administrative Code for the pre-admission screening system providing options and resources today (PASSPORT) or assisted living programs.

(3) The provider will involve the individual and/or caregiver(s) in the selection of items to be purchased on the individual's behalf.

~~(F)~~(E) All providers ~~shall~~ will maintain a record at their place of business for each individual served in accordance with the requirements set forth in rule 5160-44-31 of the Administrative Code, or with the requirements set forth in Chapter 173-39 of the Administrative Code for the PASSPORT program. For each service provided, the record ~~shall~~ will include:

(1) The individual's name;

(2) Date of service;

(3) A detailed description of each expense;

(4) A receipt for each expense;

(5) Verification the individual was involved in the selection of all items; and

(6) The individual's signature to verify receipt of the service. ~~If the signature requirement cannot be met at the time of service, the provider may accept an electronic signature or standard signature via regular mail from the individual, or otherwise obtain signature no later than at the next face-to-face visit with the individual.~~

~~(G) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.~~

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02
Prior Effective Dates:	07/01/2019, 02/01/2020, 06/12/2020 (Emer.), 12/10/2020

5160-44-27 **Nursing facility-based level of care home and community-based services programs: home care attendant services.**

(A) The following definitions are applicable to this rule:

(1) "Adult" means an individual at least eighteen years of age.

(2) "Authorizing health care professional" means a health care professional who, pursuant to section 5166.307 of the Revised Code, authorizes a home care attendant to assist an individual enrolled on a nursing facility (NF)-based level of care waiver with self-administration of medication, nursing tasks, or both.

(3) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

(4) "Custodian" has the same meaning as in section 2151.011 of the Revised Code.

(5) "Gastrostomy tube" means a percutaneously inserted catheter that terminates in the stomach.

(6) "Group setting" means a situation in which a home care attendant service provider furnishes home care attendant services in accordance with this rule and as authorized by the Ohio department of medicaid (ODM), or certified by the Ohio department of aging (ODA), to two or three individuals who reside at the same address.

(7) "Guardian" has the same meaning as in section 2111.01 of the Revised Code.

(8) "Health care professional" means a physician or registered nurse who holds a current, valid unrestricted license.

(9) "Home care attendant" means a provider, holding a valid medicaid provider agreement in accordance with section 5166.301 of the Revised Code and paragraph (G) of this rule, who is authorized to provide home care attendant services to a specific individual enrolled on a NF-based level of care waiver.

(10) "Individual enrolled on a NF-based level of care waiver" and "individual" mean the same as "consumer" as defined in section 5166.30 of the Revised Code.

(11) "Jejunostomy tube" means a percutaneously inserted catheter that terminates in the jejunum.

(12) "Medication" means a drug as defined in section 4729.01 of the Revised Code.

(13) "Minor" means an individual under eighteen years of age.

(14) "Nursing facility (NF) -based level of care waiver" and "waiver" mean the MyCare Ohio and Ohio home care waivers administered by ODM and the PASSPORT waiver administered by ODA.

(15) "Nursing tasks" means skilled tasks that would otherwise be performed by a registered nurse (RN), or a licensed practical nurse (LPN) at the direction of an RN.

(16) "Oral medication" means any medication that can be administered through the mouth, through a gastrostomy tube or jejunostomy tube if through a pre-programmed pump, or through a syringe. Oral medication may include medication administered through a metered dose inhaler.

(17) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(18) "Practice of nursing as a registered nurse," "practice of nursing as a licensed practical nurse (LPN)", and "registered nurse (RN)" have the same meanings as in section 4723.01 of the Revised Code. "Registered nurse" includes an advance practice nurse as defined in section 4723.01 of the Revised Code.

(19) "RN home care attendant service visit" means the ~~face-to-face~~ visit every ninety days between the RN and the individual receiving home care attendant services as required by paragraph (G)(~~10~~8) of this rule. The ~~face-to-face~~ visit may be conducted by ~~telephone or electronically~~via telehealth, unless the individual's needs necessitate ~~a face-to-face~~ in-person visit.

(20) "Schedule II, " "schedule III," "schedule IV" and "schedule V" have the same meaning as in section 3719.01 of the Revised Code.

(21) "Topical medication" means any medication applied to the outer skin, including transdermal medications and eye, ear and nose drops. Topical medication may also include vaginal or rectal suppositories.

(B) Home care attendant services are services provided to an individual enrolled on a waiver by an unlicensed non-agency provider in accordance with this rule. Home care attendant services are tasks that would otherwise be performed by an RN or an LPN at the direction of an RN. Home care attendant services include:

(1) Assistance with self-administration of medications as set forth in paragraph (E) of this rule.

(2) Assistance with the performance of nursing tasks as set forth in paragraph (F) of this rule.

(3) Tasks performed as part of personal care aide services as described in rule 5160-46-04 or 173-39-02.11 of the Administrative Code when performed during a home care attendant service visit. Personal care aide tasks are not reimbursable separately as personal care aide services when they are performed during a home care attendant service visit.

(C) Home care attendant services may be provided:

(1) In the individual's home or in the community; and

(2) To assist an individual to function in the workplace without duplicating workplace accommodations.

(D) If the individual has an authorized representative as ~~defined in rule 5160-1-33 of the Administrative Code~~5166.3010 of the Revised Code, the authorized representative ~~shall~~ will be present and awake during the delivery of home care attendant services.

(E) Assistance with self-administration of medication.

(1) A home care attendant ~~shall~~ will only assist an individual enrolled on a waiver with the self-administration of ~~only~~ the following medication:

(a) Oral medications;

(b) Topical medications;

(c) Subcutaneous injections only for routine doses of insulin;

(d) Programming of a pump only used to deliver a routine dose of insulin;

(e) Medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and

(f) Doses of schedule II, schedule III, schedule IV and schedule V drugs only when administered orally or topically.

(2) Medication ~~shall~~ will be maintained in its original container and the attached label ~~shall~~ will match the dosage and means of administration set forth on the ODM 02389 "Home Care Attendant Medication Authorization" form ~~(11/2015)~~. The

label on the container ~~shall~~ will display all of the following information for the individual enrolled on a waiver:

(a) The individual's full name;

(b) A dispensing date within the prior twelve months; and

(c) The exact dosage and means of administration.

(3) For schedule II, schedule III, schedule IV and schedule V drugs, all of the following ~~additional requirements shall~~ apply:

(a) Medication(s) ~~shall~~ will have a warning label on the bottle;

(b) During the first visit, the home care attendant ~~shall~~ will count the medication(s) in the presence of the individual enrolled on a waiver or the authorized representative and ~~shall~~ will record the count on a log located in the individual's clinical record.

(c) The medication(s) ~~shall~~ will be recounted by the home care attendant in the presence of the individual enrolled on a waiver or the authorized representative at least monthly, and the count ~~shall~~ will be reconciled on a log located in the individual's clinical record. The home care attendant ~~shall~~ will notify the authorizing health care professional, in writing, within twenty-four hours if:

(i) Medication is missing; or

(ii) The count of medication(s) cannot be reconciled.

(d) The medication(s) ~~shall~~ will be stored separately from all other medications, and secured and locked at all times when not being administered in order to prevent access by unauthorized persons.

(F) Assistance with the performance of nursing tasks.

(1) A home care attendant may ~~provide assistance~~ assist with the performance of nursing tasks not expressly excluded in accordance with paragraph (F)(2) of this rule.

(2) A home care attendant ~~shall~~ may not assist an individual who is receiving home care attendant services with the performance of any of the following nursing tasks:

(a) Intravenous (IV) insertion, removal or discontinuation;

(b) Intramuscular injections;

(c) IV medication administration;

(d) Subcutaneous injections, except for routine doses of insulin pursuant to paragraph (E)(1)(c) of this rule;

(e) Programming of a pump used to deliver medications (including, but not limited to epidural, subcutaneous and IV), except for routine doses of insulin pursuant to paragraph (E)(1)(d) of this rule;

(f) Insertion or initiation of infusion therapies; and

(g) Central line dressing changes.

(3) Performance of nursing tasks ~~shall~~ will be summarized and submitted on the ODM 02390 "Home Care Attendant Skilled Task Authorization" form ~~(11/2015)~~.

(G) In order to provide services to an individual enrolled on a waiver and to submit a claim for reimbursement, home care attendants ~~shall~~ will meet all of the following requirements:

(1) As part of the medicaid provider agreement application process, provide ODM, ODA or their designee with evidence to its satisfaction of the following:

(a) Submission of the ODM 02389 "Home Care Attendant Medication Authorization" form ~~(11/2015)~~ and/or ODM 02390 "Home Care Attendant Skilled Task Authorization" form ~~(11/2015)~~ as prescribed by paragraph (H) of this rule.

(b) Successful completion of at least one of the following:

(i) A competency evaluation program or training and competency evaluation program approved or conducted by the director of health under section 3721.31 of the Revised Code, and registration as active or in good standing on the Ohio nurse aide registry maintained by the director of health under section 3721.32 of the Revised Code; or

(ii) A training program and competency evaluation program for home health aides as specified in 42 C.F.R. 484.4 and 484.36, if the person met those standards as they existed on or before January

12, 2018, or 42 C.F.R. 484.80 and 484.115, if the person met those standards since they were adopted on January 13, 2018. A person is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the person's most recent completion of this program(s), there has been a continuous period of twenty-four consecutive months during none of which the person furnished services described in 42 C.F.R. 409.40 (as in effect on October 1, ~~2020~~2023); or

(iii) A certified vocational program in a health care field, and written testing and skills testing by return demonstration; or

(iv) A written attestation of training, instruction, and as appropriate, skills testing by return demonstration prior to initiation of service provision on:

(a) Appropriate and safe techniques in personal hygiene and grooming that include: bed, tub, shower and partial bath techniques, shampoo in sink, tub or bed, nail and skin care, oral hygiene, toileting and elimination, safe transfer and ambulation, normal range of motion and positioning, and adequate nutrition and fluid intake.

(b) The maintenance of a clean, safe and healthy environment, including but not limited to, house cleaning and laundry, dusting furniture, sweeping, vacuuming and washing floors, kitchen care (including dishes, appliances and counters), bathroom care, emptying and cleaning bedside commodes and urinary catheter bags, changing bed linens, washing inside windows within reach from the floor, removing trash and folding, ironing and putting away laundry.

(c) Meal preparation, including special diet preparation, grocery purchase, planning and shopping, and running errands.

(d) The physical, emotional and developmental needs of individuals, including the need for privacy and respect for individuals and their property.

(e) Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.

(f) Basic elements of body functioning and changes in body function that should be reported to a supervisor.

(g) Basic safety requirements and knowledge of emergency procedures.

(h) Reading and recording temperature, pulse and respiration.

(i) Observation, reporting and documentation of individual status and services provided.

(j) Communication skills, including the ability to read, write and make brief and accurate oral or written reports.

(c) Completion of training and instruction, prior to ~~beginning~~ the provision of home care attendant services, ~~about how to deliver the specific~~ regarding the delivery of the home care attendant services authorized by the individual's authorizing health care professional. The training ~~shall~~ will be specific to the individual enrolled on a waiver and may be provided by the individual's authorizing health care professional, the individual receiving services or the authorized representative in cooperation with the individual's health care professional as indicated on the ODM 02389 "Home Care Attendant Medication Authorization" form ~~(11/2015)~~ and/or ODM 02390 "Home Care Attendant Skilled Task Authorization" form ~~(11/2015)~~, as appropriate.

(d) Performance of a successful return demonstration of the home care attendant service to be provided if requested by the individual enrolled on a waiver or the authorizing health care professional.

(e) Completion and maintenance of first aid certification from a class that ~~may be~~is not solely internet-based and that ~~does not have to include~~includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course, and certification that education was received from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.

(f) Completion and maintenance of cardiopulmonary resuscitation (CPR) certification from a class that ~~may be~~is not solely internet-based ~~that does not have to include~~and that includes hands-on training by a certified CPR instructor and a successful return demonstration of what was learned in the course. ~~Maintenance of CPR certification may be counted toward~~

~~the in-service continuing education required pursuant to paragraph (G)(11) of this rule.~~ Current providers and those provider-applicants whose applications are pending as of the effective date of this rule shall have one hundred and eighty days from the effective date of this rule to meet this requirement.

(2) Be a non-agency provider who holds ~~a current, valid~~ an active medicaid provider agreement as a home care attendant and ~~complies~~ who maintains compliance with sections 5166.30 to 5166.3010 of the Revised Code and applicable rules set forth in Chapters 173-39, 5160-44, 5160-45 and 5160-46 of the Administrative Code.

(3) Request reimbursement for the provision of home care attendant services in accordance with rule 5160-1-06.1 of the Administrative Code for Ohio Department of Aging certified providers or 5160-46-06.1 of the Administrative Code for providers of Ohio Department of Medicaid administrated waiver programs.

(4) Not be the authorizing health care professional of the individual receiving services.

(5) Not be ~~the~~ an authorized representative of the individual receiving services.

(6) Not be the legally responsible family member as that term is defined in rule 5160-45-01 of the Administrative Code of the individual receiving services.

(7) Not be the legal guardian or foster caregiver of the individual receiving services.

~~(8) Provide home care attendant services for only one individual, unless authorized to provide services in a group setting in accordance with paragraph (G)(9) of this rule.~~

~~(9) If authorized, provide services to two or three individuals enrolled on a waiver in a group setting. Authorization on a case-by-case basis is subject to approval based on a clinical review conducted by ODM or ODA in consultation with the individual receiving services, the authorized representative, authorizing health care professional, care manager and the individual's team. The clinical review will address the needs and desires of the individual receiving services, the skill level and training needs of the home care attendant, the ability to ensure the health and welfare of the individuals enrolled on a waiver served by the home care attendant, and the back-up plan.~~

~~(10)~~(8) In collaboration with the individual receiving services, ~~Secure~~ secure the services of an RN~~, with agreement of the individual receiving services,~~ and

participate in ~~a face-to-face~~ an in-person visit ~~at least every ninety days~~ with the individual receiving services, the authorized representative, and the RN for the purpose of answering any questions the home care attendant and/or individual receiving services, or authorized representative have about meeting care needs, medications and other issues. ~~The face-to-face visit may be conducted by telephone or electronically, unless the individual's needs necessitate a face-to-face visit.~~

(a) At least twice per year, the RN will conduct RN home care attendant service visits in-person.

(i) All other RN home care attendant service visits may be conducted via telehealth, unless the individual's needs necessitate an in-person visit.

~~(a)~~(b) The RN performing an RN home care attendant service visit ~~shall~~will:

(i) Possess a current, valid and unrestricted license with the Ohio board of nursing;

(ii) Possess an active Ohio medicaid provider agreement;

(iii) Comply with the conditions of participation as set forth in rule 5160-44-31 of the Administrative Code.

~~(b)~~(c) The RN ~~shall~~ will be present at the first visit between the home care attendant and individual upon the initiation of home care attendant services. ODM, ODA, or their designee ~~shall~~ will also be present at the first visit.

~~(c)~~(d) The home care attendant and the RN ~~shall~~ will document the activities of each visit in the clinical record of the individual receiving services.

~~(d)~~(e) The home care attendant ~~shall~~ will discuss the results of the RN visit with ODM, ODA or their designee, the individual receiving services and/or the authorized representative.

~~(e)~~(f) When the RN performs an RN home care attendant service visit, the RN ~~shall~~ will bill the state plan nursing assessment code set forth in appendix A to rule 5160-12-08 of the Administrative Code.

~~(11) Completion of at least twelve hours of continuing education annually to enhance the skills and competencies of the provider relevant to his or her job responsibilities and support person-centered service delivery.~~

(H) If authorized on the person-centered services plan, a home care attendant may provide services to two or three individuals enrolled on a waiver in a group setting.

~~(H)~~(I) The ODM 02389 "Home Care Attendant Medication Authorization" form ~~(11/2015)~~ and/or the ODM 02390 "Home Care Attendant Skilled Task Authorization" form ~~(11/2015)~~, as appropriate, ~~shall~~ will contain all of the following:

(1) Written consent from the individual enrolled on a waiver or the authorized representative, as applicable, allowing the home care attendant to provide home care attendant services, and assuming responsibility for directing the home care attendant. ~~If the individual is unable to provide the signature at the time of service, the individual is to submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the provider.~~

(2) A written statement from the authorizing health care professional attesting that the individual enrolled on a waiver or the authorized representative has demonstrated the ability to direct the home care attendant. The written statement ~~shall~~ will also indicate whether the home care attendant has demonstrated the ability to furnish the home care attendant service to the individual enrolled on a waiver. The statement ~~shall~~ will include all of the following:

(a) The name and address of the individual receiving home care attendant services;

(b) A description of the specific nursing task or self-administration of medication that the home care attendant will assist with, including, in the case of assistance with self-administration of medication, the name, dosage, and route of administration of the medication;

(c) The times or intervals when the home care attendant is to assist the individual receiving services with the self-administration of each dosage of the medication or with the performance of nursing tasks;

(d) The dates on which the home care attendant is to begin and cease providing assistance;

(e) A list of severe adverse reactions that the home care attendant ~~shall~~ will report to the individual's health care professional should the individual experience one or more reactions;

(f) At least one telephone number at which the home care attendant can reach the individual's health care professional in an emergency for consultation after contacting emergency personnel;

(g) At least one contact number at which the home care attendant can reach the authorizing health care professional when the home care attendant observes that scheduled medication(s) is missing or cannot be reconciled; and

(h) Instructions the home care attendant ~~shall~~ will follow when assisting the individual receiving services with the performance of a nursing task or the self-administration of medications, including, instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies.

~~(I)~~(J) The individual enrolled on a waiver ~~shall~~ will participate with ODM, ODA, or their designee in the development and maintenance of a written back-up plan prior to initiation of services. The authorizing health care professional and/or the home care attendant may also participate in the development and maintenance of the back-up plan.

(1) The back-up plan ~~shall~~ will meet the needs of the individual enrolled on a waiver in the event:

(a) The regularly scheduled home care attendant cannot or does not meet his or her obligation to provide services to the individual receiving services; or

(b) The individual receiving services and/or the authorized representative is not able to direct home care attendant services.

(2) As authorized by ODM, ODA, or their designee,

(a) Waiver nursing as set forth in rule 5160-44-22 of the Administrative Code, and/or private duty nursing or home health nursing as set forth in Chapter 5160-12 of the Administrative Code, may be used as back-up to assist with self-administration of medications and the performance of nursing tasks;

(b) Personal care aide services as set forth in rule 5160-46-04 of the Administrative Code may be used as back-up for personal care aide tasks in an ODM-administered waiver;

(c) Personal care services as set forth in rule 173-39-02.11 of the Administrative Code may be used as back-up for personal care tasks in the PASSPORT waiver; and

(d) Back-up may include informal caregivers.

~~(J)~~(K) All home care attendants service providers ~~shall~~ will maintain a clinical record for each individual served in accordance with the requirements set forth in rule 5160-44-31 of the Administrative Code.

(1) Storage ~~shall~~ of the clinical record will be in a manner that protects the confidentiality of these records and will be in a secure location that may be the individual's residence or primary location where the individual receives services.

~~(2) Storage shall be at the provider's place of business other than the individual's residence or primary location where the individual receives services.~~

~~(3)~~(2) Each clinical record ~~shall~~ will include:

(a) Identifying information including name, address, date of birth, gender/ gender identity, race, significant phone numbers and health identification numbers of the individual.

(b) Information regarding the individual's medical diagnoses, treatment and preferences.

(c) The individual's medication profile, as applicable.

(d) The individual's treatment administration record, as applicable.

(e) The name and contact information for all of the licensed health care professionals serving the individual.

(f) The name of and current contact information for the individual's parent/ guardian/authorized representative and/or emergency contact.

(g) A copy of the initial and all subsequent person-centered services plans.

(h) All known drug and food interactions, allergies and dietary needs, preferences and/or restrictions.

(i) A copy of any advance directives including, but not limited to, a "do not resuscitate order" (DNR) or a "medical power of attorney," if they exist.

(j) The ODM 02389 "Home Care Attendant Medication Authorization" form ~~(11/2015)~~ and/or the ODM 02390 "Home Care Attendant Skilled Task Authorization" form ~~(11/2015)~~, as appropriate.

(k) Documentation of home care attendant services performed or not performed, arrival and departure times, and the dated signature of the provider, and individual receiving services or the authorized representative, verifying the service delivery upon its completion and arrival and departure times. The signature method of choice for the individual receiving services or the authorized representative ~~shall~~ will be documented on the person-centered services plan, and ~~shall~~ will include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature. If the individual is unable to provide the signature at the time of service, the individual is to submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than within three business days of the completion of the service delivery that requires signature. ~~at the next face-to-face visit with the provider.~~

(l) A copy of the log detailing the count and reconciliation of schedule II, schedule III, schedule IV and schedule V drugs for which assistance with self-administration is provided.

(m) Service notes, signed and dated by the home care attendant, documenting all communications with ODM, ODA or their designee, health care professionals including the authorizing health care professional, and other members of the individual's team, and documenting the general condition of the individual, any unusual events occurring during the visit, and the service tasks performed.

(n) Documentation of the ~~face-to-face~~ RN home care attendant service visits every ninety days between the home care attendant, individual enrolled on a waiver and RN, and of any resulting activities, in accordance with paragraph (G)(~~10~~8) of this rule.

(L) Unless the clinical record described in paragraph (K) of this rule is maintained in the home of the individual and accessible to team members, the home care attendant will maintain another record which:

(1) Includes communication logs going back no less than sixty calendar days in a format agreed upon by the individual and provider for the purpose of promoting communication between team members.

(2) Any other documentation required by the individual.

(3) Is maintained in a place and manner that is accessible to the individual and other team members chosen by the individual at the individual's residence or primary service location.

(4) Is maintained in a manner that protects the confidentiality of the individual.

~~(K) All home care attendant service providers shall also maintain documentation at the individual's residence or primary service location in order to encourage sharing of information between caregivers and enhance person-centered care.~~

~~(1) Storage shall be in a manner that protects the confidentiality of these records.~~

~~(2) The documentation may include, but not be limited to, a communication log, as designated in the individual's person-centered services plan.~~

~~(3) Documents shall reflect a minimum of at least the past sixty calendar days, with the individual's right to maintain more if he or she so chooses.~~

~~(4) The individual shall identify the location in his or her residence or the primary location where the documentation will be safely maintained.~~

~~(L)~~(M) If ODM, ODA, or their designee determines that the individual enrolled on a waiver cannot meet the requirements of this rule, or the health and welfare of the individual receiving home care attendant services cannot be ensured, then ODM, ODA, or their designee, at its discretion, may prohibit the individual from receiving home care attendant services. The individual ~~shall~~ will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

~~(M) ODM and ODA are authorized to deem any provider approved by ODM or certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM or certification by ODA for the same or similar services.~~

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02, 5166.30
Rule Amplifies:	5162.03, 5164.02, 5166.30, 5166.301, 5166.302, 5166.303, 5166.304, 5166.305, 5166.306, 5166.307, 5166.308, 5166.309, 5166.3010
Prior Effective Dates:	07/01/2010, 08/01/2015, 01/01/2019, 02/01/2020, 06/12/2020 (Emer.), 12/10/2020

5160-44-31 **Ohio department of medicaid (ODM)-administered waiver programs: provider conditions of participation.**

(A) An ODM-administered waiver service provider ~~shall~~ will maintain a professional relationship with the individuals to whom they provide services. Providers ~~shall~~ will furnish services in a manner that is in accordance with the individual's approved person-centered services plan, is attentive to the individual's needs, and maximizes the individual's independence. A provider ~~shall~~ will refrain from any behavior that may detract from the goals, objectives and services outlined in the individual's approved person-centered services plan and/or that may jeopardize the individual's health and welfare.

(B) An ODM-administered waiver service provider ~~shall~~will:

(1) Maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.

(2) Comply with all provider requirements set forth in Chapters 5160-44 and 5160-45 of the Administrative Code, and Chapter 5160-46 or 5160-58 of the Administrative Code, depending upon the waiver(s) for which the provider is rendering services. Provider requirements include:

(a) Provider enrollment as set forth in rule 5160-45-04 of the Administrative Code;

(b) Criminal record checks as set forth in rule 5160-45-07 or 5160-45-08, as applicable, and rule 5160-45-11 of the Administrative Code;

(c) Incident reporting as set forth in rule 5160-44-05 of the Administrative Code; and

(d) Provider monitoring, reviews and oversight as set forth in rules 5160-45-06 and 5160-45-09 of the Administrative Code.

(3) Be at least eighteen years of age, including the provider and its employees, if applicable.

(4) Be able to read, write, and understand English at a level that enables the provider to comply with all applicable program requirements.

(5) Be able to effectively communicate with the individual.

(6) Deliver services professionally, respectfully and legally.

(7) Ensure that individuals to whom the provider is rendering ODM-administered waiver services are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being. Upon entering into a medicaid provider agreement, and annually thereafter, all providers including all employees who have direct contact with individuals enrolled on an ODM-administered waiver, must acknowledge in writing they have reviewed rule 5160-44-05 of the Administrative Code regarding incident management and related procedures.

(8) Work with the individual and case manager to coordinate service delivery, including:

(a) Agreeing to provide and providing services in the amount, scope, location and duration they have capacity to provide, and as specified on the individual's approved person-centered services plan.

(b) Participating in the development of a back-up plan in the event that providers are unable to furnish services on the appointed date and time.

(c) Contacting the individual and the case manager in the event the provider is unable to render services on the appointed date and time.

(i) In the case of an emergency or unplanned absence, the provider ~~shall~~ will immediately activate the back-up plan as set forth in the individual's approved person-centered services plan, verify with the individual and notify the case manager with information about the absence.

(ii) In the event of a planned absence, the provider ~~shall~~ will verify with the individual and notify the case manager no later than seventy-two hours prior to the absence with information about the absence.

(9) Upon request and within the timeframe prescribed in the request, provide information and documentation to ODM, its designee and/or the centers for medicare and medicaid services (CMS).

(10) Successfully complete ODM-mandated new provider training within ninety days after a new provider's medicaid enrollment date.

(11) Participate in all appropriate ~~on-line or web-based~~ provider trainings mandated or sponsored by ODM or its designees, including but not limited to those set forth in Chapters 5160-44, 5160-45, 5160-46 and 5160-58 of the Administrative Code.

(12) Be knowledgeable about and comply with all applicable federal and state laws, including the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (as in effect on October 1, ~~2020~~2023), and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.300 to 431.306 (as in effect on October 1, ~~2020~~2023), along with sections 5160.45 to 5160.481 of the Revised Code.

(13) Ensure that the provider's contact information, including but not limited to address, telephone number, fax number and email address, is current. In the event of a change in contact information, the provider ~~shall~~ will notify ODM via the ~~medicaid information technology system (MITS)~~Provider Network Management (PNM) portal and its designee, no later than seven calendar days after such changes have occurred.

(14) Maintain and retain all required documentation related to the services delivered during ~~the~~ each visit, including but not limited to: an individual-specific description and details of the tasks performed or not performed in accordance with the approved person-centered services plan and when required, the individual's plan of care.

(a) Verification of service delivery ~~shall~~ will include, but not be limited to, the date and location of service delivery, service start and end times, and the signatures of the provider and the individual or authorized representative.

(b) Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature ~~shall~~ will be documented on the person-centered services plan.

(c) If the individual is unable to provide the signature required by this paragraph at the time of the service, the individual is to submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than within three business days of the completion of the service delivery that requires signature. ~~at the next face-to-face visit with the provider.~~

(15) Retain all records of service delivery and billing for a period of six years after the date of receipt of the payment based upon those records, or until any initiated audit is completed, whichever is longer.

(16) Cooperate with ODM and its designee during all provider monitoring and oversight activities by being available to answer questions during reviews, and

by assuring the availability and confidentiality of individual information and other documents that may be requested as part of provider monitoring activities.

(17) To the extent not otherwise required by rule 5160-44-05 of the Administrative Code, notify ODM or its designee within twenty-four hours when the provider is aware of issues that may affect the individual and/or provider's ability to render services as directed in the individual's person-centered services plan, including when:

(a) The individual consistently declines services;

(b) The individual plans to or has moved to another residential address;

(c) There are changes in the physical, mental and/or emotional status of the individual;

(d) There are changes in the individual's environmental conditions;

(e) The individual's caregiver status has changed;

(f) The individual no longer requires medically necessary services as defined in rule 5160-1-01 of the Administrative Code;

(g) The individual's actions toward the provider are threatening or the provider feels unsafe or threatened in the individual's environment;

(h) The individual is consistently noncompliant with physician orders, or is noncompliant with physician orders in a manner that may jeopardize his or her health and welfare;

(i) The individual's requests conflict with his or her person-centered services plan and/or may jeopardize his or her health and welfare; or

(j) Any other situation that affects the individual's health and welfare.

(18) Make arrangements to accept all correspondence sent by ODM or its designee, including but not limited to, certified mail.

(19) Maintain a current e-mail address with ODM and its designee in order to receive electronic notification of any rule adoption, amendment or rescission, and any other communications from ODM or its designee

(20) Submit written notification to the individual and ODM or its designee at least thirty calendar days before the anticipated last date of service if the provider

is terminating the provision of ODM-administered waiver services to the individual. Exceptions include:

(a) The provider ~~must~~ will submit verbal and written notification to the individual and ODM or its designee at least ten days before the anticipated last date of service if the individual has been:

(i) Admitted to a hospital;

(ii) Placed in an institutional setting; or

(iii) Incarcerated.

(b) ODM may waive advance notification for a provider upon request and on a case-by-case basis.

(21) Be identified as the provider, and have specified on the individual's person-centered service plan that is prior approved by ODM or its designee, the amount of services the provider is authorized to furnish to the individual.

(22) Have a valid social security number and at least one of the following current, government-issued photographic identification cards:

(a) Driver license;

(b) State of Ohio identification card; or

(c) United States of America permanent residence card.

(C) A provider of nursing, personal care and home care attendant services under an ODM-administered waiver program ~~shall~~ will verify service delivery using an ODM-approved electronic visit verification (EVV) system in accordance with rule 5160-1-40 of the Administrative Code.

(D) At no time, ~~shall~~ will an ODM-administered waiver service provider:

(1) Engage in any behavior that causes or may cause physical, verbal, mental or emotional abuse or distress to the individual.

(2) Engage in any other behavior that may compromise the health and welfare of the individual.

(3) Engage in any activity or behavior that may take advantage of or manipulate the individual or his or her authorized representative, family or household members

or which may result in a conflict of interest, exploitation, or any other advantage for personal gain, including:

(a) Misrepresentation;

(b) Accepting, obtaining, attempting to obtain, borrowing, or receiving money or anything of value including, but not limited to gifts, tips, credit cards or other items;

(c) Being designated on any financial account including, but not limited to bank accounts and credit cards;

(d) Using real or personal property of another;

(e) Using information of another;

(f) Lending or giving money or anything of value;

(g) Engaging in the sale or purchase of products, services or personal items; and

(h) Engaging in any activity that takes advantage of or manipulates ODM-administered waiver program rules.

(4) Falsify the individual's signature, including using copies of the signature.

(5) Make fraudulent, deceptive or misleading statements in the advertising, solicitation, administration or billing of services.

(6) Submit a claim for waiver services rendered while the individual is hospitalized, institutionalized or incarcerated. The only exception is when the individual is receiving out-of-home respite as set forth on his or her person-centered services plan.

(E) While rendering services, an ODM-administered waiver service provider ~~shall~~ will not:

(1) Take the individual to the provider's place of residence.

(2) Bring children, animals, friends, relatives, other individuals or anyone else to the individual's place of residence.

(3) Provide care to persons other than the individual.

(4) Smoke without the consent of the individual.

(5) Sleep.

(6) Engage in any activity that is not related to the provision of services to the extent the activity distracts from, or interferes with, service delivery. Such activities include, but are not limited to the following:

(a) Using electronic devices for personal or entertainment purposes including, but not limited to watching television, using the computer or playing games.

(b) Making or receiving personal communications.

(c) Engaging in socialization with persons other than the individual.

(7) Deliver services when the provider is medically, physically or emotionally unfit.

(8) Use or be under the influence of the following while providing services:

(a) Alcohol.

(b) Illegal drugs.

(c) Chemical substances.

(d) Controlled substances that may adversely affect the provider's ability to furnish services.

(9) Engage in any activity or conduct that may reasonably be interpreted as sexual in nature, regardless of whether or not it is consensual.

(10) Engage in any behavior that may reasonably be interpreted as inappropriate involvement in the individual's personal beliefs or relationships including, but not limited to discussing religion, politics or personal issues.

(11) Consume the individual's food and/or drink without his or her offer and consent.

(F) ~~An ODM-administered waiver service provider shall not be designated to serve or make decisions for the individual in any capacity involving a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney, guardianship pursuant to court order, as an authorized representative, or as a representative payee as that term is described in paragraph (F)(3) of this rule, except in the following circumstances:~~Parents of minor children, spouse, and other individual's designated legal decision-making authority:

(1) Unless otherwise permitted by rule 5160-44-32 of the Administrative Code, an ODM-administered waiver service provider will not be designated to serve

or make decisions for the individual in any capacity involving a declaration for mental health treatment, general power of attorney, health care (medical) power of attorney, financial power of attorney, legal custody of a minor child, guardianship pursuant to court order, as an authorized representative, or as a representative payee.

~~(1) A provider may be appointed by the court to serve as legal guardian for the individual pursuant to Chapter 2111. of the Revised Code with the following exceptions:~~

~~(a) An attorney serving in the role of guardian may not be a provider.~~

~~(b) An agency serving in the role of guardian may not be a provider.~~

~~(2) A provider may serve as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship if the provider is the individual's parent or spouse.~~

~~(3) A provider may serve as the individual's representative payee if the provider is the individual's parent or spouse. For purposes of this rule, "representative payee" means a parent or spouse the individual designates to receive and manage payments that would otherwise be made directly to the individual.~~

~~(4)~~(2) A provider may be designated as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care (medical) power of attorney, financial power of attorney or guardianship for the individual if:

(a) The provider was serving in that capacity prior to September 1, 2005; and

(b) The provider was the individual's paid medical provider prior to September 1, 2005; and

(c) The designation is not otherwise prohibited by law.

(G) An agency provider ~~shall~~ will pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security.

(H) Non-agency providers ~~shall~~ will pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security. On an annual basis, non-

agency providers ~~must~~ will submit an ODM-approved affidavit stating that they paid their applicable federal, state and local income and employment taxes.

(I) Failure to meet the requirements set forth in this rule may result in any of the actions set forth in rules 5160-44-05, 5160-45-06 and 5160-45-09 of the Administrative Code including termination of the medicaid provider agreement in accordance with rule 5160-1-17.6 of the Administrative Code. In the event ODM proposes termination of the medicaid provider agreement, the provider may be entitled to a hearing or review in accordance with Chapter 5160-70 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5166.02, 5164.02
Prior Effective Dates:	08/01/2005, 10/25/2010, 02/01/2015, 01/01/2018, 01/01/2019, 02/01/2020, 06/12/2020 (Emer.), 12/10/2020, 10/01/2021

5160-45-01 **Ohio department of medicaid (ODM) -administered waiver program: definitions.**

The following terms apply to Ohio department of medicaid (ODM) -administered waiver programs:

(A) "Abuse" has the same meaning as set forth in rule 5160-44-05 of the Administrative Code.

(B) "Accreditation commission for health care" or "(ACHC)" is a national organization that evaluates and accredits agencies seeking to participate in the medicare and medicaid programs. For the purpose of providing services to individuals enrolled on an ODM-administered waiver, ACHC-accredited agencies are "otherwise-accredited agencies" that can provide the same ODM-administered waiver services that community health accreditation program (CHAP) -accredited and the joint commission-accredited agencies provide.

(C) "Activity of daily living" has the same meaning as set forth in rule 5160-3-05 of the Administrative Code.

(D) "Agency provider" is an entity that is eligible to furnish services in the medicaid program upon execution of a medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code.

(E) "Applicant" is a person who is requesting a determination of eligibility for enrollment in an ODM-administered waiver.

(F) "Authorized representative" is a person the individual appoints to act on his or her behalf in accordance with rule 5160-1-33 of the Administrative Code.

(G) "Case management contractor" is the entity designated by ODM to provide case management services to individuals enrolled on an ODM-administered waiver. This may include a contracted case management agency, a MyCare Ohio plan and/or ODM itself.

(H) "Case management services" are the administrative activities that link, coordinate and monitor the services, supports and resources provided to an individual enrolled on an ODM-administered waiver.

(I) "Case manager" is a registered nurse (RN), licensed social worker (LSW) or licensed independent social worker (LISW) employed by the case management contractor who provides case management services to individuals enrolled on an ODM-

administered waiver. The case manager is responsible for developing and monitoring the individual's person-centered services plan as described in rule 5160-44-02 of the Administrative Code.

(J) "Case manager contact" is a phone conversation, email exchange or other electronic communication with an individual or provider that ensures the exchange of information between the case manager and the individual. Electronic communications without response are not considered a case manager contact.

(K) "Case manager visit" is ~~a face-to-face~~ an in-person encounter between an individual and a case manager in the individual's residence. Meetings and encounters at locations other than the individual's place of residence are only considered visits when completed in an institutional or other service delivery location for the purpose of completing an assessment for waiver eligibility and/or developing a discharge plan. Case managers ~~must~~ will interact (i.e., converse, make visual contact and otherwise engage the individual at his or her functional ability) during every case manager visit. ~~The face-to-face encounter between an individual and a case manager may be conducted by telephone or electronically, unless the individual's needs require a face-to-face visit~~.

(L) "Clinical record" is a record containing written documentation that ~~must~~ will be maintained by each ODM-administered waiver service provider.

(M) "Community health accreditation program" or "(CHAP)" is a national organization that evaluates and accredits agencies seeking to participate in the medicare and medicaid programs. For the purpose of providing services to individuals enrolled on an ODM-administered waiver, CHAP-accredited agencies are "otherwise-accredited agencies" that can provide the same ODM-administered waiver services that ACHC-accredited and the joint commission-accredited agencies provide.

(N) "Comprehensive assessment" is an evaluation of an individual's long-term service and support needs that is used to determine level of care and eligibility for enrollment in an ODM-administered waiver, and to inform service planning. The comprehensive assessment includes ~~a face-to-face~~ an in-person evaluation and examines an individual's activities of daily living, instrumental activities of daily living, natural supports, cognition, health status, behavioral health status, safety and environment.

(O) "Electronic Visit Verification" or "EVV" has the same meaning as set forth in rule 5160-1-40 of the Administrative Code.

(P) "Group rate" has the same meaning as set forth in rules 5160-46-06 and 5160-46-06.1 of the Administrative Code.

(Q) "Group setting" has the same meaning as set forth in rules 5160-44-22, 5160-44-27, 5160-46-04, 5160-46-06, and 5160-46-06.1 of the Administrative Code.

(R) "Health and safety action plan" or "HSAP" is the document created between ODM and its designee and an individual enrolled on an ODM-administered waiver that identifies the interventions recommended by the case management contractor to remedy risks to the health, safety and welfare of the individual.

(S) "Health and welfare" is the basis for an assurance to CMS made by ODM that necessary safeguards are taken to protect the health, safety and welfare of individuals enrolled on an ODM-administered waiver. CMS will not grant an ODM-administered waiver, and may terminate an existing ODM-administered waiver, if ODM fails to assure compliance with this requirement. Health and welfare safeguards include policies and procedures that direct the following:

(1) Risk and safety evaluations and planning;

(2) Incident management;

(3) Housing and environmental safety evaluations and planning;

(4) Restraint, seclusion and restrictive intervention evaluations and planning;

(5) Medication management; and

(6) Natural disaster and public emergency response planning.

(T) "Helping Ohioans move, expanding (HOME) choice" mean Ohio's money follows the person program described in Chapter 5160-51 of the Administrative Code that assists individuals with transferring from an institutional long term care setting to a home setting.

(U) "Intermediate care facility for individuals with intellectual disabilities (ICF-IID) level of care" has the same meaning as that term is set forth in rule 5123-8-01 of the Administrative Code.

(V) "Incident" has the same meaning as set forth in rule 5160-44-05 of the Administrative Code.

(W) "Individual" is a person who is enrolled on an ODM-administered waiver.

(X) "Individual waiver agreement" is the ODM-approved agreement signed by an individual and the case manager that assures the individual is voluntarily enrolling in an ODM-administered waiver as an alternative to receiving medicaid long term

services and supports in an institutional setting. The responsibilities an individual ~~must~~ will understand and agree to as a condition of waiver enrollment are set forth in the agreement.

(Y) "Institutional setting" is any nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID) or hospital.

(Z) "Instrumental activity of daily living" has the same meaning as set forth in rule 5160-3-05 of the Administrative Code.

(AA) "Intermediate level of care" has the same meaning as set forth in rule 5160-3-08 of the Administrative Code.

(BB) "Legally responsible family member," as that term is used in ODM-administered waivers, is an individual's spouse, or in the case of a minor, the individual's birth or adoptive parent.

(CC) "Medical necessity" and "medically necessary" have the same meaning as set forth in rule 5160-1-01 of the Administrative Code.

(DD) "Medicare-certified home health agency" is any entity, agency or organization that has and maintains medicare certification as a home health agency, and is eligible to participate in the medicaid program upon execution of a medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code.

(EE) "MyCare Ohio plan" has the same meaning as set forth in rule 5160-58-01 of the Administrative Code.

(FF) "Natural supports" are unpaid caregivers who provide care to an individual.

(GG) "Neglect" has the same meaning as set forth in rule 5160-44-05 of the Administrative Code.

(HH) "Non-agency provider" means an RN, a licensed practical nurse (LPN) at the direction of an RN, a non-agency personal care aide, or a non-agency home care attendant who is eligible to participate in the medicaid program upon execution of a medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code.

(II) "Nursing facility-based level of care" has the same meaning as set forth in rule 5160-3-05 of the Administrative Code.

(JJ) "ODM-administered waiver programs" are home and community-based services waivers administered by ODM in accordance with Chapters 5160-44, 5160-45, 5160-46 and/or 5160-58 of the Administrative Code, as applicable.

(KK) "ODM-administered waiver provider" is any entity or non-agency provider eligible to furnish ODM-administered waiver services upon execution of a medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code.

(LL) "Otherwise-accredited agency" is an entity that has and maintains accreditation by a national accreditation organization for the provision of services upon execution of a medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code. The national accreditation organization ~~shall~~ will be approved by CMS.

(MM) "Person-centered services plan" is the document that identifies person-centered goals, objectives and interventions selected by the individual and team to support ~~him or her in his or her~~the individual in their community of choice. The plan addresses the assessed needs of the individual by identifying medically-necessary services and supports provided by natural supports, medical and professional staff and community resources.

(NN) "Person-centered planning" is a process directed by the individual, that identifies his or her strengths, values, capacities, preferences, needs and desired outcomes. The process includes team members who assist and support the individual to identify and access medically necessary services and supports needed to achieve his or her defined outcomes in the most inclusive community setting. The individual and team identify goals, objectives and interventions to achieve these outcomes which are documented on the person-centered services plan by the case manager. The person-centered service planning process is described in rule 5160-44-02 of the Administrative Code.

(OO) "Provider" means a person or agency that has entered into a medicaid provider agreement for the purpose of furnishing ODM-administered waiver services. In the case of an agency, provider includes the agency's respective staff who have direct contact with individuals.

(PP) "Provider oversight contractor" is the entity designated by ODM to perform quality assurance, monitoring and oversight functions related to the ODM-administered waiver program.

(QQ) "Plan of care" is the medical treatment plan that is established, approved and signed by the treating physician. The plan of care is not the same as the person-centered services plan.

(RR) "Reportable incident" has the same meaning as set forth in rule 5160-44-05 of the Administrative Code.

(SS) "Restraint" is any of the following:

(1) "Chemical restraint," i.e., the use of any sedative psychotropic drug exclusively to manage or control behavior; or

(2) "Mechanical restraint," i.e., the use of any device to restrict an individual's movement or function, or that is used for any purpose other than positioning and/or alignment; or

(3) "Physical restraint," i.e., any hands-on or physical method that is used to restrict the movement or function of the individual's head, neck, torso, one or more limbs or entire body.

(TT) "Restrictive intervention" is any action or activity that limits an individual's rights for a period of time to assure an individual's health, safety or welfare. Restrictive intervention may only be used to safeguard individuals from accident or injury, or to help promote optimal health and welfare. Restrictive interventions include, but are not limited to, locking cabinets, using door alarms or limiting access to a desired item contingent upon a behavior or activity.

(UU) "Seclusion" or "time-out" is any restriction that is used to address a specified behavior and that prevents the individual from leaving a location for any period of time. Seclusion may include, but is not limited to, preventing an individual from leaving an area until he or she is calm.

(VV) "Significant change" is a variation in the health, care or needs of an individual that warrants further evaluation to determine if changes to the type, amount or scope of services are needed. Significant changes include, but are not limited to, differences in health status, caregiver status, residence/location of service delivery and service delivery that result in the individual not receiving waiver services for thirty days.

(WW) "Skilled level of care" has the same meaning as set forth in rule 5160-3-08 of the Administrative Code.

(XX) "Team" is a group of persons freely chosen by the individual to assist and support him or her in the development and implementation of his or her person-centered services plan. The team is led by the individual and ~~must~~ will include the case manager. It can also include, but is not limited to, the individual's friends, family and natural supports, the physician and other professionals and providers.

(YY) "The joint commission" is a national organization that evaluates and accredits agencies that seek to participate in the medicare and medicaid programs. For the purpose of providing services to individuals enrolled on an ODM-administered waiver, the joint commission-accredited agencies are "otherwise-

accredited agencies" that can provide the same ODM-administered waiver services that ACHC-accredited and CHAP-accredited agencies provide.

(ZZ) "Time away" is a restrictive intervention during which an individual is directed away from a location or activity using only verbal prompting to address a specified behavior. The individual is able to return to the location or activity at his or her choosing. Time away ~~shall~~ will never include the use of a physical prompt or escort. The use of a physical prompt or required timeline for re-engaging in an activity will elevate the intervention to seclusion.

(AAA) "Unexplained death" has the same meaning as set forth in rule 5160-44-05 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	05/01/1998, 09/29/2000, 03/01/2002 (Emer.), 05/30/2002, 07/01/2006, 02/15/2007, 10/26/2009, 07/01/2010, 10/25/2010, 07/01/2015, 02/01/2020, 06/12/2020 (Emer.), 10/17/2020

5160-45-03 **Ohio department of medicaid (ODM) -administered waiver program: individual rights and responsibilities.**

Enrollment on an Ohio department of medicaid (ODM) -administered waiver is voluntary. Individuals enrolled on an ODM-administered waiver in accordance with rule 5160-46-02 of the Administrative Code ~~shall~~ will be informed of their rights and responsibilities. Individuals also have choice and control over the arrangement and provision of home and community-based waiver services, and the selection and control over the direction of approved waiver service providers.

(A) Individual rights.

An individual enrolled in an ODM-administered waiver has the right to:

(1) Be treated with dignity and respect.

(2) Be protected from abuse, neglect, exploitation and other threats to personal health, safety and well-being.

(3) Appoint an authorized representative to act on their behalf in accordance with 5160-1-33 of the Administrative Code.

(4) Receive waiver services in a person-centered manner that is in accordance with an approved person-centered services plan, is attentive to the individual's needs and maximizes personal independence.

(5) Conduct person-centered training of their waiver service providers.

(6) Choose his or her case management agency (CMA) and case managers, and

(a) Have the case manager explain what the ODM-administered waiver is, how it will assist the individual and what the individual's rights and responsibilities are;

(b) Participate with the case manager and the team in the person-centered services plan development process, and when possible, lead the process;

(c) Request assistance with recruitment of providers;

(d) Be able to effectively communicate with the case manager and team and receive information in a manner that is easy to understand;

(e) Be able to meet privately with the case manager;

(f) Receive ongoing assistance from the case manager; and

(g) Be able to request changes in CMA, as necessary, subject to ODM's approval.

(7) Make informed choices regarding the services and supports he or she receives and from whom, including provider-managed agency providers, non-agency providers, or participant-directed providers as those terms are defined in rule 5160-45-01 of the Administrative Code.

(8) Obtain the results of criminal records checks about current agency providers or provider applicants pursuant to section 5164.342 of the Revised Code and rules 5160-45-07 and 5160-45-11 of the Administrative Code.

(9) Obtain the results of criminal records checks about current non-agency providers or provider applicants pursuant to section 5164.341 of the Revised Code and rules 5160-45-08 and 5160-45-11 of the Administrative Code.

(10) Access files, records or other information related to the individual's health care.

(11) Be assured of confidentiality of personal and sensitive health care information pursuant to relevant confidentiality and information disclosure laws.

(12) Request assistance with problems, concerns and issues, and suggest changes without fear of repercussion.

(13) Be fully informed about how to contact the case manager and ODM with problems, concerns, issues or inquiries.

(14) Be informed of the right to appeal decisions made by ODM or its designee about waiver eligibility or services pursuant to division 5101:6 of the Administrative Code.

(B) Individual responsibilities.

(1) Upon enrollment in an ODM-administered waiver, the individual ~~must~~ will sign an ODM-approved waiver agreement accepting responsibility to: ~~for the provisions in paragraphs (B)(1)(a) to (B)(1)(t) of this rule. The signature requirement in paragraph (B)(1) of this rule may be satisfied by an electronic signature or standard signature via regular mail, or otherwise in no instance any later than at the next face-to-face visit with the case manager.~~

(a) Participate in, and cooperate during assessments to determine eligibility and enrollment in the waiver and service needs.

(b) Decide who, besides the case manager, will participate in the service planning process.

(c) Participate in, and cooperate with, the case manager and team in the development and implementation of person-centered services plans and plans of care.

(d) Participate in the recruitment, selection and dismissal of his or her providers.

(e) Participate in the development and maintenance of back-up plans that meet the needs of the individual.

(f) Work with the case manager and/or physician and the provider to identify and secure additional training within the provider's scope of practice in order to meet the individual's specific needs.

(g) Not direct the service provider to act in a manner that is contrary to relevant ODM-administered waiver program requirements, medicaid rules and regulations and all other applicable laws, rules and regulations.

(h) Verify service delivery in a manner that includes, but is not limited to; the date and location of service delivery, start and end times, and the signatures of the provider and the individual or authorized representative. All signatures ~~shall~~ will be obtained at the end of every visit or upon completion of the scheduled service. When services are rendered in multiple visits per day, signatures ~~must~~ will be obtained upon completion of each visit.

(i) Notify the case manager when any change in provider is necessary. Notification ~~shall~~ will include the end date of the former provider, and the start date of the new provider.

(j) Authorize the exchange of information for development of the person-centered services plan with all of the individual's service providers, and in compliance with the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (October 1, ~~2021~~2023) and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.000 to 431.306 (October 1, ~~2021~~2023) along with sections 5160.45 to 5160.481 of the Revised Code.

(k) Provide accurate and complete information including, but not limited to medical history.

(l) Utilize services in accordance with the approved person-centered services plan.

(m) Communicate to the provider personal preferences about the duties, tasks and procedures to be performed, and when appropriate, about provider performance concerns.

(n) Report to the case manager any service delivery issues including, but not limited to, service disruption, complaints and concerns about the provider, and/or health and safety issues.

(o) Keep scheduled appointments and notify the provider and case manager if he or she is going to miss a scheduled visit or service.

(p) Treat the case manager, team and providers with respect.

(q) Report to the case manager any significant changes, as defined in rule 5160-45-01 of the Administrative Code, that may affect the provision of services.

(r) Report to the case manager, in accordance with rule 5160-44-05 of the Administrative Code, incidents that may impact the health and welfare of the individual.

(s) Work with the case manager and team to resolve problems and concerns.

(t) Refuse to participate in dishonest or illegal activities involving providers, caregivers and team members.

(2) When an individual receives services from an agency provider, the individual ~~shall~~ will identify a location in his or her residence where a record containing a copy of his or her medication profile, if one exists, ~~shall~~ will be safely maintained. The record may also include the individual's medication administration record, treatment administration record, aide assignment, person-centered services plan and plans of care.

(3) When an individual receives services from a non-agency provider, the individual ~~shall~~ will identify a location in his or her residence where a copy of the clinical record will be safely maintained.

(C) If the individual fails to meet the requirements set forth in paragraph (B) of this rule, and/or the health and welfare of the individual receiving services from a non-agency provider cannot be assured, then the individual may be required to receive services from only agency providers. The individual ~~shall~~ will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	07/01/1998, 08/13/2007, 07/01/2010, 04/01/2015, 06/12/2020 (Emer.), 10/17/2020, 10/01/2021

5160-46-04 **Ohio home care waiver: definitions of the covered services and provider requirements and specifications.**

This rule sets forth definitions of some services covered by the Ohio home care waiver. This rule also sets forth the provider requirements and specifications for the delivery of those Ohio home care waiver services. Providers are also subject to the conditions of participation set forth in rule 5160-44-31 of the Administrative Code. Services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) Personal care aide services.

(1) "Personal care aide services" are defined as services provided pursuant to the person-centered services plan (PCSP) that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. ~~If the individual's person-centered services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service.~~ If the provider cannot perform IADLs, the provider ~~shall~~ will notify ODM or its designee, in writing, of the service limitations before inclusion on the individual's ~~person-centered services plan~~PCSP. Personal care aide services include:

(a) Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;

(b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors and waste disposal;

(c) Paying bills and assisting with personal correspondence as directed by the individual; and

(d) Accompanying or transporting the individual to Ohio home care waiver services, medical appointments, other community services, or running errands on behalf of that individual.

(2) Personal care aide services do not include tasks performed, or services provided as part of the home maintenance and chore services set forth in rule 5160-44-12 of the Administrative Code.

(3) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the ~~person-centered services plan~~PCSP.

(4) Personal care aides ~~shall~~ will not administer prescribed or over-the-counter medications to the individual, but may, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph (C) of rule 4723-13-02 of the Administrative Code, help the individual self-administer medications by:

(a) Reminding the individual when to take the medication, and observing to ensure the individual follows the directions on the container;

(b) Assisting the individual by taking the medication in its container from where it is stored and handing the container to the individual;

(c) Opening the container for an individual who is physically unable to open the container;

(d) Assisting an individual who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and

(e) Assisting an individual who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the individual.

(5) Personal care aide services ~~shall~~ will be delivered by one of the following:

(a) An employee of a medicare-certified, or otherwise-accredited home health agency; or

(b) A non-agency personal care aide.

(6) In order to be a provider and submit a claim for reimbursement, all personal care aide service providers ~~shall~~ will meet the following:

~~(a) May be the individual's legally responsible family member as that term is defined in rule 5160-45-01 of the Administrative Code if the legally responsible family member is employed by a medicare-certified, otherwise-accredited, or other ODM-approved agency.~~

~~(b) May be the foster caregiver of the individual if the foster caregiver is employed by a medicare-certified, otherwise-accredited, or other ODM-approved agency.~~

~~(c)~~(a) ~~Be providing~~Provide personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit.

~~(d)~~(b) Comply with the additional applicable provider-specific requirements as specified in paragraph (A)(7) or (A)(8) of this rule.

(7) Medicare-certified and otherwise-accredited agencies ~~shall~~ will ensure that personal care aides meet the following requirements:

(a) Before commencing service delivery, the personal care aide ~~shall~~will:

(i) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.80 (as in effect on October 1, ~~2021~~2023), and

(ii) Obtain and maintain first aid certification from a program that may be from a class that is not solely internet-based, and that includes ~~does not have to include~~ hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

(b) Maintain evidence of the completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education ~~shall~~ willbe initiated immediately, and ~~shall~~ will be completed annually thereafter.

(c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN, at the direction of an RN in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, ~~shall~~will:

(i) Conduct a face-to-face individual home visit explaining the expected activities of the personal care aide, and identifying the individual's personal care aide services to be provided.

(ii) Conduct a face-to-face individual home visit at least every sixty days while the personal care aide is present and providing care to evaluate the provision of personal care aide services, and the

individual's satisfaction with care delivery and personal care aide performance. The visit ~~shall~~ will be documented in the individual's record.

(iii) Discuss the evaluation of personal care aide services with the case manager.

(d) ~~Face-to-face visits referenced in this paragraph may be conducted by telephone or electronically, unless the individual's needs necessitate a face-to-face visit.~~At least twice per year, the RN will conduct RN assessment visits in-person. All other RN assessment service visits may be conducted via telehealth, unless the individual's needs necessitate an in-person visit. When the RN performs an RN assessment visit, the RN will bill the state plan nursing assessment code set forth in appendix A to rule 5160-12-08 of the Administrative Code.

(e) Parent of minor children, spouse, and relatives appointed legal decision making authority may only serve as direct care worker in accordance with 5160-44-32 of the Administrative Code.

(8) Non-agency personal care aides ~~shall~~ will meet the following requirements:

(a) Before commencing service delivery personal care aides ~~shall~~ will have:

(i) Obtained a certificate of completion within the last twenty-four months for either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.80 (as in effect on October 1, ~~2021~~2023); or other equivalent training program. The program ~~shall~~ will include training in the following areas:

(a) Personal care aide services as defined in paragraph (A)(1) of this rule;

(b) Basic home safety; and

(c) Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.

(ii) Obtained and maintain first aid certification from a class that ~~may be~~ is not solely internet-based and that ~~does not have to include~~ includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

(b) Complete ~~twelve~~ six hours of in-service continuing education annually that ~~shall~~ will occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to, health and welfare of the individual, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.

(c) Comply with the individual's or the individual's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the individual or the case manager.

(d) Comply with ODM monitoring requirements in accordance with rule 5160-45-06 of the Administrative Code.

(9) All personal care aide providers ~~shall~~ will maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited agencies, ~~shall~~ will maintain the clinical records at their place of business. Non-agency personal care aides ~~shall~~ will maintain the clinical records at their place of business, and maintain a copy in the individual's residence. For the purposes of this rule, the place of business ~~shall~~ will be a location other than the individual's residence. At a minimum, the clinical record ~~shall~~ will contain:

(a) Identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers of the individual.

(b) The medical history of the individual.

(c) The name of individual's treating physician.

(d) A copy of the initial and all subsequent ~~person-centered services plans~~PCSP.

(e) Documentation of all drug and food interactions, allergies and dietary restrictions.

(f) A copy of any advance directives including, but not limited to, do not resuscitate (DNR) order or medical power of attorney, if they exist.

(g) Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and individual or the individual's authorized representative, verifying the service delivery upon completion of service delivery. The individual or the individual's authorized representative's signature of choice ~~shall~~ will be documented on the individual's ~~person-centered services plan~~PCSP, and ~~shall~~ will include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(h) Progress notes signed and dated by the personal care aide, documenting all communications with the case manager, treating physician, other members of the team, and documenting any unusual events occurring during the visit, and the general condition of the individual.

(i) A discharge summary, signed and dated by the departing non-agency personal care aide or the RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the individual, or when the individual no longer needs personal care aide services. ~~The summary should include documentation regarding progress made toward achievement of goals as specified on the individual's all services plan and indicate any recommended follow-ups or referrals.~~

(i) The summary should include documentation regarding progress made toward achievement of goals as specified on the individual's PCSP and indicate any recommended follow-ups or referrals.

(ii) The discharge summary is not required in the event the individual dies.

(B) Adult day health center services.

(1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to individuals who are age eighteen or older. A qualifying adult day health center ~~must~~ will be a freestanding building or a space within another building that ~~shall~~ will not be used for other purposes during the provision of ADHCS.

(a) An adult day health center ~~shall~~ will provide:

(i) Waiver nursing services as set forth in rule 5160-44-22 of the Administrative Code, or personal care aide services as set forth in paragraph (A)(1) of this rule;

(ii) Recreational and educational activities; and

(iii) At least one meal, but no more than two meals, per day that meet the individual's dietary requirements.

(b) An adult day health center may also provide:

(i) Skilled therapy services as set forth in rule 5160-12-01 of the Administrative Code; and

(ii) Transportation of the individual to and from ADHCS.

(c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided in a day.

(d) All of the services set forth in paragraphs (B)(1)(a) and (B)(1)(b) of this rule and delivered by an adult day health center ~~shall~~ will not be reimbursed as separate services.

~~(e) ADHCS providers approved to provide services on the effective date of this rule may also furnish ADHCS described in paragraph (B) of this rule at the individual's place of residence, telephonically, or electronically.~~

(2) ADHCS do not include services performed in excess of what is approved pursuant to, and specified on, the individual's ~~person-centered services plan~~PCSP.

(3) In order to be a provider and submit a claim for reimbursement, providers of ADHCS ~~shall~~ will operate the adult day health center in compliance with all federal, state and local laws, rules and regulations.

(4) All providers of ADHCS ~~shall~~will:

(a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, ~~2021~~2023).

(b) Provide for replacement coverage of a loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps an individual takes to file a liability claim. Upon request, verification of coverage ~~shall~~ will be provided to ODM or its designee.

(c) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training every twelve months.

(d) Ensure that any waiver nursing services provided are within the nurse's scope of practice as set forth in rule 5160-44-22 of the Administrative Code.

(e) Provide task-based instruction to direct care staff providing personal care aide services as set forth in paragraph (A)(1) of this rule.

(f) At all times, maintain a one to six ratio of paid direct care staff to individuals.

(5) Providers of ADHCS ~~shall~~ will maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record ~~shall~~ will contain the following:

(a) Identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers of the individual.

(b) The medical history of the individual.

(c) The name of the individual's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of any advance directive including, but not limited to, DNR order or medical power of attorney, if they exist.

(f) Documentation of all drug and food interactions, allergies and dietary restrictions.

(g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the individual's arrival and departure times. ~~Nothing shall prohibit the~~ The use of technology-based systems may be used in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the ~~ADHCS provider is~~ individual no longer needs ADHCS. ~~going to provide services to the individual, or when the individual no longer needs ADHCS.~~ The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(i) Documentation of the information set forth in rule 5160-44-22 of the Administrative Code when the individual is provided waiver nursing and/or skilled therapy services.

(C) Supplemental adaptive and assistive device services.

(1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. All supplemental adaptive and assistive device services ~~shall~~ will be prior-approved by ODM or its designee. ODM or its designee ~~shall~~ will only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

(a) Reimbursement for medical equipment, supplies and vehicle modifications ~~shall~~ will not exceed a combined total of ten thousand dollars within a calendar year per individual.

(b) ODM or its designee ~~shall~~ will not approve the same type of medical equipment, supplies and devices for the same individual during the same calendar year, unless there is a documented need for ongoing medical equipment, supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.

(c) ODM or its designee ~~shall~~ will not approve the same type of vehicle modification for the same individual within the same three-year period, unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

(d) Supplemental adaptive and assistive device services do not include:

(i) Items considered by the federal food and drug administration as experimental or investigational;

(ii) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;

(iii) Equipment, supplies or services furnished in excess of what is approved in the individual's ~~person-centered services plan~~PCSP;

(iv) Replacement equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of perceived misuse, abuse or negligence; and

(v) Activities described in paragraph (C)(2)(c) of this rule.

(2) Vehicle modifications.

(a) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, scooter/ wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same individual. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.

(b) Before the authorization of a vehicle modification, the individual and, if applicable, any other person(s) who will operate the vehicle ~~shall~~ will provide ODM or its designee with documentation of:

(i) A valid driver's license, with appropriate restrictions, and if requested, evidence of the successful completion of driver training from a qualified driver rehabilitation specialist, or a written statement from a qualified driver rehabilitation specialist attesting to the driving ability and competency of the individual and/or other person(s) operating the vehicle;

(ii) Proof of ownership of the vehicle to be modified;

(iii) Vehicle owner's collision and liability insurance for the vehicle being modified; and

(iv) A written statement from a certified mechanic stating the vehicle is in good operating condition.

(c) Vehicle modifications do not include:

(i) Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (C)(2)(a) of this rule;

(ii) Routine care and maintenance of vehicle modifications and devices;

(iii) Permanent modification of leased vehicles;

(iv) Vehicle inspection costs;

(v) Vehicle insurance costs;

(vi) New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and

(vii) Services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) In order to be a provider and submit a claim for supplemental adaptive and assistive device services, the provider ~~shall~~will:

(a) Ensure all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services.

(b) Ensure the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.

(4) Providers of supplemental adaptive and assistive device services ~~shall~~ will maintain a clinical record for each individual they serve in a manner that protects the confidentiality of these records. At a minimum, the clinical record ~~shall~~ will include:

(a) Identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers of the individual.

(b) The name of the individual's treating physician.

(c) A copy of the initial and all subsequent ~~person-centered services plans~~PCSP.

(d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. ~~Nothing shall prohibit the~~ The use of technology-based systems may be used in collecting and maintaining the documentation required by this paragraph.

(5) The authorization of supplemental adaptive and assistive device services may be combined with other waiver services to meet the assessed needs of the individuals. In such instances, individual waiver service limits as described in paragraph (C)(1)(a) of this rule still apply.

(D) Supplemental transportation services.

(1) "Supplemental transportation services" are transportation services that are not available through any other resource that enable an individual to access waiver services and other community resources specified on the individual's ~~person-centered services plan~~PCSP. Supplemental transportation services include, but are not limited to assistance in transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.

(2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) Agency supplemental transportation service providers ~~shall~~will:

(a) Maintain a current list of drivers.

(b) Ensure all drivers providing supplemental transportation services are age eighteen or older.

(c) Maintain a copy of the valid driver's license for each driver.

(d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services.

(e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.

(f) Obtain and maintain a certificate of completion of a course in first aid for each driver used to provide supplemental transportation services that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course, and certification that education was received from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting. ~~may be from a class that is soley through the internet, and does not have to include hands-on training from a certified first aid instructor and the performance of a successful return demonstration of what was learned in the course.~~

(g) Ensure drivers are not the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.

(h) Ensure drivers are not the individual's foster caregivers.

(4) Non-agency supplemental transportation service providers ~~shall~~will:

(a) Be age eighteen or older.

(b) Possess a valid driver's license.

(c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services.

(d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.

(e) Completion and maintenance of first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course, and certification that education was received from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.~~Obtain and maintain a certificate of completion of a course in first aid that may be from a class that is soley through the internet, and does not have to include hands-on training from a certified first aid instructor and the performance of a successful return demonstration of what was learned in the course.:~~

(f) Not be the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.

(g) Not be the individual's foster caregiver.

(5) All supplemental transportation service providers ~~shall~~ will maintain documentation that, at a minimum, includes a log identifying the individual transported, the date of service, pick-up point, destination point, mileage for each trip, and the signature of the individual receiving supplemental transportation services, or the individual's authorized representative. The individual's or authorized representative's signature of choice ~~shall~~ will be documented on the individual's ~~person-centered services plan~~PCSP and ~~shall~~ will include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

~~(E) ODM is authorized to deem any provider certified by ODA or the Ohio department of developmental disabilities (DODD) to provide waiver services as having satisfied the requirements for approval by ODM for the same or similar services.~~

(E) OHCW covered services described in this rule will be provided in accordance with the individual's PCSP.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 07/01/1998, 07/01/2006, 10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019, 07/01/2019, 02/01/2020, 06/12/2020 (Emer.), 12/10/2020, 10/01/2021