CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Home and community-based services waiver alignment: Phase 1

Rule Number(s): 5160-44-13, 5160-44-17, 5160-44-22, 5160-44-27, 5160-44-31, 5160-46-04.1, 5160-46-04

Date: September 10, 2018

Rule Type:

- [X] New
- [ ] Amended
- [ ] 5-Year Review
- [X] Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

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

   Both the Ohio Department of Medicaid (ODM) and the Ohio Department of Aging (ODA) administer home and community-based services (HCBS) nursing facility level of care waivers. ODM-administered HCBS waivers include the MyCare Ohio and Ohio Home Care waivers. ODA-administered HCBS waivers include the preadmission screening system providing options and

resources today (PASSPORT) and Assisted Living waivers. Each waiver is described under its own chapter of the OAC and while services across waivers may be similar, they are not uniform.

It is not uncommon for individuals receiving services through these waivers to move from one waiver to another depending on criteria such as age, Medicare eligibility, service needs and/or county of residence. Also, often providers deliver services to individuals across all waivers, but are made to adhere to different standards depending on the waiver enrollment of the individual they are serving. This causes confusion among individuals and providers alike and results in a lack of continuity of care.

To bring consistency to the ODM and ODA administered waiver programs to benefit individuals and providers, the two agencies have been collaborating to align the OAC rules governing the various waiver programs. This rule package reflects phase one of the HCBS waiver alignment collaboration and includes service alignment efforts that will not result in a budget impact.

5160-44-13 "Nursing facility-based level of care home and community-based services programs: home modification services," is being proposed as new to implement home modification services in Chapter 5160-44 of the Administrative Code. This rule sets forth the service description, authorization process and amount, service limitations and provider requirements. It replaces language currently set forth in Rule 5160-46-04 of the Administrative Code.

5160-44-17 "Nursing facility-based level of care home and community-based services programs: out-of-home respite," is being proposed as new to implement out-of-home respite services in Chapter 5160-44 of the Administrative Code. This rule sets forth the service description, provider qualifications and clinical record keeping requirements. It replaces language currently set forth in Rule 5160-46-04 of the Administrative Code.

5160-44-22 "Nursing facility-based level of care home and community-based services programs: waiver nursing services," is being proposed as new to implement waiver nursing services in Chapter 5160-44 of the Administrative Code. This rule sets forth the service description, limitations, provider qualifications and requirements, and clinical record keeping requirements. It replaces language currently set forth in Rule 5160-46-04 of the Administrative Code.

5160-44-27 "Nursing facility-based level of care home and community-based services programs: home care attendant services," is being proposed as new to implement home care attendant services in Chapter 5160-44 of the Administrative Code. This rule sets forth the definitions related to the rule, service description, individual expectations, provider qualifications and requirements, and clinical record keeping requirements. This rule is replacing Rule 5160-46-04.1 of the Administrative Code.

5160-44-31 "Nursing facility-based level of care home and community-based services programs: provider conditions of participation," is being proposed as new to implement the HCBS provider conditions of participation in Chapter 5160-44 of the Administrative Code. This rule sets forth the

core conditions of participation a provider must meet to render services to an individual enrolled in an ODM-administered waiver program. It is replacing Rule 5160-45-10 of the Administrative Code for providers of services which are being moved to Chapter 5160-44 of the Administrative Code.

5160-46-04.1 "Ohio home care waiver program: home care attendant services," is being proposed for rescission and will be replaced by rule 5160-44-27 of the Administrative Code.

5160-46-04 "Ohio home care waiver: definitions of the covered services and provider requirements and specifications," is being proposed for rescission and replacement to align with implementation of HCBS rules in Chapter 5160-44 of the Administrative Code. This rule sets forth the covered services and provider requirements for nursing facility-based HCBS waivers administered by ODM. Waiver nursing, home delivered meals, home modification, emergency response and out of home respite services are being removed from this rule and implemented in Chapter 5160-44 of the Administrative Code. Home delivered meals and personal emergency response systems services are addressed within another rule package.

2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

Ohio Revised Code Section 5166.02.

3. 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, for the Centers for Medicare and Medicaid Services (CMS) to approve a 1915(c) home and community-based services (HCBS) waiver, a state must meet certain assurances about the operation of the waiver. These assurances are spelled out in 42 C.F.R. 441.302, and include:

> *(a) "Health and Welfare -Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. Those safeguards must include—*
> *(1)Adequate standards for all types of providers that provide services under the waiver;*
> *(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver;"*

Thus, providers of HCBS waiver services must be qualified, i.e., only those agencies and persons who meet the state's qualification requirements can provide services to waiver participants. The proposed rules will assist the State in assuring the health and welfare of waiver participants by

establishing specific qualifications and requirements that providers must meet in order to render waiver services.

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

   These rules are consistent with federal requirements. They define specific processes for meeting HCBS waiver program provider eligibility requirements as required by CMS.

5. **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. 44 I. 302(a) through the provision of services by qualified providers. The State is doing so by establishing requirements that providers must meet to be HCBS waiver service providers.

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

   Successful outcomes are measured through a finding of compliance with provider standards. The expectation is that adherence to the provider requirements will result in a reduced number of incidents that threaten the health and welfare of individuals participating in the waiver program. This is evidenced, in part, by no adverse findings resulting from structural reviews and investigation of alleged provider occurrences.

Development of the Regulation

7. **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.

   ODM has been convening the HCBS Rules Workgroup since May 2013, to draft and review OAC rules governing ODM-administered waivers. This stakeholder group generally meets monthly (in-person and by phone) and plays a critical role in the ODM and ODA HCBS waiver alignment initiative. All rules in this package have been provided to the HCBS Rules Workgroup for review and comment.

   The HCBS Rules Workgroup email group includes over 900 members. The workgroup consists of individuals enrolled on ODM-administered waivers, agency and independent service providers and members of no less than the following organizations:

Ability Center
Bureau of Vocational Rehabilitation
Caregiver Homes
Caresource
CareStar
Coalition of Community Living
Council on Aging
Creative Housing/Creative Renovations
Disability Rights Ohio
Home Care by Black Stone
Home Care Network
Leading Age Ohio
LEAP
Molina Healthcare
Ohio Academy of Senior Health Sciences, Inc.
Ohio Assisted Living Association
Ohio Association of Area Agencies on Aging
Ohio Association of Senior Centers
Ohio Council for Home Care and Hospice
Ohio Department of Developmental Disabilities
Ohio Health Care Association
Ohio Long Term Care Ombudsman
Ohio Olmstead Task Force
Public Consulting Group (PCG)
Senior Resource Connection
United Healthcare

8. **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 identifying the service specifications and provider requirements for each of the HCBS waiver services. Throughout the HCBS waiver alignment initiative, stakeholders provided a tremendous amount of feedback related to the rule drafts. Often the suggested edits were incorporated, and updated drafts were vetted.

9. **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.

10. **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?**

Both ODM and ODA policies were considered by the interagency HCBS waiver alignment team. However, the language must meet the federal and state guidelines under which both ODM and ODA-administered waivers are permitted to operate.

11. Did the Agency specifically consider a performance-based regulation? Please explain. ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

No. Performance-based regulations are not deemed appropriate and are not authorized by statute.

12. 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. The regulations are reviewed by the interagency legal and legislative staff to ensure there is no duplication within the rules. The HCBS waiver alignment initiative will further ensure the regulation on these providers is not duplicative.

13. 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.

A robust effort will be employed by ODM and ODA to notify HCBS waiver participants and service providers of plans regarding the implementation of aligned OAC rules. Initial notification of the rules will occur via a variety of communication methods including ODM's issuance of emails to agency and independent providers and electronic communication via the provider oversight contractor's (PCG) website.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

Currently, there are approximately 4,027 non-agency personal care aides, 1,736 registered nurses (RN)/licensed practical nurses (LPN), and 54 home care attendants serving individuals enrolled on an ODM-administered waiver. There are also 726 Medicare-certified home health agencies, 68 otherwise-accredited agencies and approximately 578 ancillary service providers that also furnish services to individuals.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

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 home owner'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. Home modification providers must also maintain licensure, insurance and bonding for general contracting services of applicable jurisdictions and provide proof upon request.

OAC rule 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 for replacement coverage due to theft, property damage and/or personal injury.

OAC rule 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.

OAC rule 5160-44-27 requires home care attendant service 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/or training specific to the services to be provided. The provider must submit a written attestation of training, instruction and skills testing. Providers must complete first aid certification and CPR certification and must complete at least 12 hours of continuing education annually. Home care attendant services providers must maintain clinical documentation in their place of business and within the individual's home.

OAC rule 5160-44-31 requires all providers of home and community-based services (HCBS) waiver services to meet certain criteria including having a valid driver license, state of Ohio identification card of United States of America permanent residence card. Providers may incur

administrative expenses associated with provider training that agencies require for staff regarding provider conditions of participation.

OAC rule 5160-46-04 requires providers to comply with all the requirements outlined above. These requirements are being removed from this rule and implemented in the rules listed above. In addition, the new rule includes a requirement for home health agencies to be Medicare-certified or otherwise accredited by a national accreditation body. An adult day health center must provide for replacement coverage due to theft, property damage and/or personal injury. 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. Supplemental transportation service providers must possess a valid driver's license. Supplemental transportation service providers must also 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. Non-agency 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.

Providers may incur costs associated with continuing education requirements and records retention pertaining to their service as set forth in these rules.

c. Quantify the expected adverse impact from the regulation.

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.

Contractors providing home modification services may incur the following kinds of approximate costs:

- Two percent of the value of work for general liability insurance (e.g., $20,000 cost for $1,000,000 in "sales");
- $100-$125 for a $10,000 bond for each city;
- $200-$350 fee for city licensure;
- Five percent of the value of work, or a minimum of $250 for drawings;
- Permitting varies from $75 and up to $100s, depending upon the scope of work. SOURCE: *Creative Housing Inc.*

Licensure of nursing facilities will vary by such things as licensure fee, building/fire inspection, bed costs, construction costs, if necessary, and staffing, etc. SOURCE: *The Ohio*

Department of Health.

The cost of a license for an intermediate care facility is $50 for the first year of operation. Then, based on the outcome of their first-year licensure review, they can be issued a 1 ($50), 2 ($75) or 3-year ($100) license. SOURCE: *Ohio Department of Developmental Disabilities.*

A prospective provider can receive home health aide/competency training through adult vocational schools. An informal survey of courses approximates this cost at $200-$500 depending on the program and type of instruction. State tested nurse assistant (STNA) programs costs also vary but are generally around $400.

The cost of 12 hours of continuing education each year for a home care attendant will vary by subject, source and location. A home care attendant would be responsible for training costs and would not be paid wages while receiving training.

First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about $70-75. Tuition can range anywhere from $50 to over $110, with lower rates in more rural counties.

5160-46-04 requires agencies to be Medicare-certified and to execute provider agreements as a condition of participation and compliance. The certification process from start to finish can take six to nine months. Administrative staff involved invest as much as 80 or more hours to complete the initial Medicare certification process, and five or more hours per agency administrator to secure the provider agreement from a non-agency provider and/or an accredited agency. The cost of Medicare certification varies by agency and can be more than a $250,000 endeavor depending on the number of staff hired to support the process. SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

Providers must revalidate a provider agreement every 5 years and this includes a $569 fee. The revalidation may take from one to two hours at a rate of $29 an hour to complete the revalidation process. SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

To maintain Medicare certification, a survey is required to be completed once every three years (or sooner, depending on the number of deficiencies found on the survey). This process is an on-going process for agencies. It is a compliance issue, keeping up with all the new rules and regulations. On average an agency spends a minimum of .5 FTE of a nurse's salary on this compliance piece and if it is a larger agency, it can be 1 to1.5 FTEs. At $29 per hour, that could amount to between $60,000- $90,000 per year. (This number does not include benefits). SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

"Otherwise accredited agencies" such as those accredited by The Joint Commission may

spend approximately $16,000 every three years for conducting their on-site survey. SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

Agencies incur approximately $190 in costs for RN assignment/oversight/supervision of aides at least every 60 days, or as often as every 14 days. OAC 5160-44-22 requires the RN to conduct a face-to-face visit with the LPN prior to initiating care, at least every sixty days, and at least each one hundred and twenty days (with the individual present) to evaluate that the LPN's provision of nursing services are in accordance with the plan of care. The cost of an RN visit, which is not reimbursed by ODM is $31.50/hour. So, within the first four months the RN visits would equal at least $126 or more that is not reimbursed by ODM. SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

It is a challenge to determine the total cost of maintaining records because the number of documents needed, and time spent gathering these documents would be different for each individual. SOURCE *Ohio Council for Home Care and Hospice and Midwest Care Alliance*

Training and competency testing have been estimated to cost an agency approximately $2,704 for a group of ten potential personal care aides. More than $2,200 of these costs are attributable to the cost of instruction (RN/PT instructors) over a 75-hour period. The actual aide handbook is estimated to cost approximately $30 per person. Agencies also incur additional costs for wages, testing and materials. An independent provider can receive training through adult vocational schools (approximate cost: $500). Some state tested nurse assistant (STNA) programs are Diversified Health Programs encompassing Aide Training to Medical Assistants. SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

Twelve hours of continuing education each year is estimated to cost an agency approximately $1,821 for a group of ten staff. This estimate includes nearly $500 for the cost of materials/administrative costs/instruction and the remainder is for payment of wages to staff while they undergo training. An independent provider would be responsible for training costs and would not be paid wages while receiving training. SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

First aid training is estimated to cost an agency $394 every two years for a group of staff. This includes $174 for the cost of materials/administrative costs/instruction and the remainder is for payment of wages to staff while they undergo training. Again, an independent provider would be responsible for training costs and would not be paid wages while receiving instruction. SOURCE: *Ohio Council for Home Care and Hospice and Midwest Care Alliance.*

Supplemental transportation as well as other waiver service providers incur $23-$26 in licensure fees. Additionally, transportation providers' auto insurance costs will vary by both city and vehicle. According to an analysis of auto insurance rates in Ohio conducted by valuepenguin.com, average minimum coverage premiums range from $428 to $1,428 per year.

15. 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

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

No, not applicable for this program.

17. 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?

Not applicable for this program.

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

Providers may contact the Ohio Department of Medicaid (ODM) provider hotline at 1-800-686-1516.

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 or the home maintenance/chore service set forth in rule 5160-44-12 of the Administrative Code. 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.

(4) Routine maintenance and repair of a modification.

(5) Expenses related to new home builds.

(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)(5)(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.

Replaces: 5160-46-04

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

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 for caregivers normally providing care. The service shall include an overnight stay.

(1) An out-of-home respite provider shall 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 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 not be reimbursed as separate services.

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

(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:

(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 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 be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and shall 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 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 protect the confidentiality of these records.

(2) Each clinical record shall 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 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 include documentation that the RN has reviewed the plans of care with the LPN. The plan of care shall 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.

Replaces: 5160-46-04

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.), 10/10/1992, 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

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:

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

(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 Administrative Code rules adopted thereunder.

(2) Nursing tasks and activities that shall 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 shall not be used in lieu of similar services available through third-party insurers, community supports, resources or other Ohio medicaid state plan services when it has been determined an individual's needs can be met by those services.

(2) 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 limitation(s) before the provider is included on the individual's person-centered services plan.

(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, 2018);

(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 rules 5160-44-27 of the Administrative Code.

(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 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 ensure they and the nurses they employ or contract with, are in compliance with 42 CFR 484. (as in effect on October 1, 2018).

(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) In order to be a provider and submit a claim for reimbursement of waiver nursing services, the nurse delivering the service shall:

(1) Understand and comply with all applicable rules governing the home and community-based services 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 173-9, 5160-31, 5160-33, and/or 5160-38 of the Administrative Code, as applicable, for ODA-administered HCBS waiver programs.

(2) Be providing the service to one individual, 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:

(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; and

(2) Conduct a face-to-face 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.

(F) All waiver nursing service providers shall 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 be in a manner that protects the confidentiality of these records.

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

(3) Each clinical record shall 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.

(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 include documentation that the RN has reviewed the plans of care with the LPN. The plan of care shall 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 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.

(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 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 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 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 service location where the record will be safely maintained.

Replaces: 5160-46-04

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

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)(7) of this rule.

(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 rules 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, the authorized representative shall 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 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 be maintained in its original container and the attached label shall 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 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 have a warning label on the bottle;

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

(c) The medication(s) shall 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 be reconciled on a log located in the individual's clinical record. The home care attendant shall 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 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 with the performance of nursing tasks not expressly excluded in accordance with paragraph (F)(2) of this rule.

(2) A home care attendant shall 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 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 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, 2018); 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 home care attendant services, about how to deliver the specific home care attendant services authorized by the individual's authorizing health care professional. The training shall 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 is not solely internet-based and that includes hands-on training by a certified first aid instructor, 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 is not solely internet-based, 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)(8) 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 medicaid provider agreement as a home care attendant and complies with sections 5166.30 to 5166.3010 of

the Revised Code and 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 or 5160-46-06.1 of the Administrative Code.

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

(5) Not be the 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) Secure the services of an RN, with agreement of the individual receiving services, and participate in a face-to-face 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.

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

(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) The RN shall 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 also be present at the first visit.

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

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

(e) When the RN performs an RN home care attendant service visit, the RN shall 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) 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 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.

(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 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 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 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 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) The individual enrolled on a waiver shall participate with ODM, ODA, or their designee in the development and maintenance of a written back-up plan prior to inititation 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 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) All home care attendants service providers shall 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 be in a manner that protects the confidentiality of these records.

(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) Each clinical record shall 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 (7/2014) and/or the ODM 02390 "Home Care Attendant Skilled Task Authorization" form (7/2014), 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 be documented on the person-centered services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(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)(7) of this rule.

(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) 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 may prohibit the individual from receiving home care attendant services. The individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Replaces: 5160-46-04.1

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

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

(A) An ODM-administered waiver service provider shall maintain a professional relationship with the individuals to whom they provide services. Providers shall 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 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:

(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 5160-45-05 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 5160-45-05 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 immediately activate the back-up plan as set forth in the individual's approved person-centered services plan, and contact the individual and case manager and verify their receipt of information about the absence.

(ii) In the event of a planned absence, the provider shall contact the individual and case manager no later than seventy-two hours prior to the absence and verify their receipt of 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) Participate in all appropriate 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.

(11) 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, 2018), and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.300 to 431.306 (as in effect on October 1, 2018), along with sections 5160.45 to 5160.481 of the Revised Code.

(12) 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 notify ODM via the medicaid information technology system (MITS) and its designee, no later than seven calendar days after such changes have occurred.

(13) Maintain and retain all required documentation related to the services delivered during the 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 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 be documented on the person-centered services plan.

(14) 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.

(15) 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.

(16) To the extent not otherwise required by rule 5160-45-05 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.

(17) Make arrangements to accept all correspondence sent by ODM or its designee, including but not limited to, certified mail.

(18) 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

(19) 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 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.

(20) 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.

(21) 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 the Ohio home care waiver shall 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 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 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 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:

(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 if the provider is a family member.

(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) A provider may be designated 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 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 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 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 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 5160-45-05, 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

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. The 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 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 notify ODM or its designee, in writing, of the service limitations before inclusion on the individual's person-centered services plan. 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, and waste disposal;

(c) Household chores, including but not limited to washing floors, windows and walls, tacking down loose rugs and tiles; and moving heavy items to provide safe access and exit;

(d) Paying bills and assisting with personal correspondence as directed by the individual; and

(e) 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 services performed in excess of the number of hours approved pursuant to the person-centered services plan.

(3) Personal care aides shall 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.

(4) Personal care aide services shall 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.

(5) In order to be a provider and submit a claim for reimbursement, all personal care aide service providers shall meet the following:

(a) Comply with all applicable rules set forth in Chapters 5160-44, 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be at least eighteen years of age.

(d) Be identified as the provider, and have specified, on the individual's person-centered services plan that is prior-approved by ODM or its designee, the

number of hours for which the provider is authorized to furnish personal care aide services to the individual.

(e) Have a valid social security number, and one of the following forms of identification:

(i) Alien identification,

(ii) State of Ohio identification,

(iii) A valid driver's license, or

(iv) Other government-issued photo identification.

(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 foster caregiver of the individual.

(h) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit.

(i) Comply with the additional applicable provider-specific requirements as specified in paragraph (A)(6) or (A)(7) of this rule.

(6) Medicare-certified and otherwise-accredited agencies shall ensure that personal care aides meet the following requirements:

(a) Before commencing service delivery, the personal care aide shall:

(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. 484.36 (as in effect on October 1, 2018), and

(ii) Obtain and maintain 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.

(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 be initiated immediately, and shall 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:

(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 be documented in the individual's record.

(iii) Discuss the evaluation of personal care aide services with the case manager.

(d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.

(e) Be able to effectively communicate with the individual.

(7) Non-agency personal care aides shall meet the following requirements:

(a) Before commencing service delivery personal care aides shall 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. 484.36 (as in effect on October 1, 2018); or other equivalent training program. The program shall 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 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.

(b) Complete twelve hours of in-service continuing education annually that shall 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.

(e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.

(f) Be able to effectively communicate with the individual.

(8) All personal care aide providers shall 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 maintain the clinical records at their place of business. Non-agency personal care aides shall 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 be a location other than the individual's residence. At a minimum, the clinical record shall 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.

(e) Documentation of all drug and food interactions, allergies and dietary restrictions.

(f) A copy of any advance directives including, but not limited to, 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 be documented on the individual's person-centered services plan, and shall 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 multidisciplinary 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.

(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 be a freestanding building or a

space within another building that shall not be used for other purposes during the provision of ADHCS.

(a) An adult day health center shall 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 not be reimbursed as separate services.

(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.

(3) In order to be a provider and submit a claim for reimbursement, providers of ADHCS shall:

(a) Comply with all applicable rules set forth in Chapters 5160-44, 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider on the individual's person-centered services plan, that is prior-approved by ODM or its designee, the number of hours

for which the provider is authorized to furnish adult day health center services to the individual.

(d) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.

(4) All providers of ADHCS shall:

(a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, 2018).

(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 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 1:6 ratio of paid direct care staff to individuals.

(5) Providers of ADHCS shall 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 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 use of technology-based systems 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 no longer 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 be prior-approved by ODM or its designee. ODM or its designee shall 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 not exceed a combined total of ten thousand dollars within a calendar year per individual.

(b) ODM or its designee shall 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 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;

(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 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:

(a) Comply with all applicable rules set forth in Chapters 5160-44, 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the individual.

(d) Ensure all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services.

(e) 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 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 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.

(d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(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. 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) In order to be a provider and submit a claim for supplemental transportation services, the provider shall:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified on the individual's person-centered services plan that is prior-approved by ODM or its designee, the amount of supplemental transportation services the provider is authorized to render to the individual.

(4) Agency supplemental transportation service providers shall:

(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:

(i) Is not provided solely through the internet;

(ii) Includes hands-on training provided by a certified first aid instructor; and

(iii) Requires the individual to perform 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.

(5) Non-agency supplemental transportation service providers shall:

(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) Obtain and maintain a certificate of completion of a course in first aid that:

(i) Is not provided solely through the internet;

(ii) Includes hands-on training provided by a certified first aid instructor; and

(iii) Requires the individual to perform 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.

(6) All supplemental transportation service providers shall 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 be documented on the individual's person-centered services plan and shall include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

Replaces: 5160-46-04

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

TO BE RESCINDED

5160-46-04 **Ohio home care waiver: definitions of the covered services and provider requirements and specifications.**

This rule sets forth the definitions of the services covered by the Ohio home care waiver. This rule also sets forth the provider requirements and specifications for the delivery of Ohio home care waiver services. The services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) Waiver nursing services.

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

(a) All nurses providing waiver nursing services to Ohio home care waiver individuals shall:

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

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

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

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

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

(ii) IV medication administration;

(iii) 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);

(iv) Insertion or initiation of infusion therapies;

(v) Central line dressing changes; and

(vi) Blood product administration.

(2) "Personal care aide services" as defined in paragraph (B) of this rule may be reimbursed as waiver nursing services when provided incidental to waiver nursing services as defined in paragraph (A)(1) of this rule and performed during an authorized waiver nursing visit.

(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 psychiatric nurse;

(c) Visits performed for the purpose of conducting an RN assessment as set forth in rule 5160-12-08 of the Administrative Code, including but not limited to an outcome and assessment information set (OASIS) assessment or any other assessment;

(d) RN consultations as set forth in rule 5160-12-08 of the Administrative Code, including but not limited to, those performed by RNs for the sole purpose of directing LPNs in the performance of waiver nursing services or directing personal care aides or home health aides employed by a medicare-certified home health agency or otherwise accredited agency;

(e) Visits performed for the sole purpose of meeting the supervisory requirements (including any visit) pursuant to paragraph (B)(6)(c) of this rule;

(f) Visits performed for the sole purpose of meeting the home care attendant service RN visit requirements set forth in rules 5160-46-04.1 and 173-39-02.24 of the Administrative Code; or

(g) Services performed in excess of the number of hours approved pursuant to, and as specified on, the individual's all services plan.

(4) Waiver nursing services may be provided on the same day as, but not concurrently with, an RN assessment and/or an RN consultation as set forth in rule 5160-12-08 of the Administrative Code.

(5) In order to be a provider and submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must meet all of the following requirements:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider.

(d) 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.

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

(f) Be identified as the provider and have specified on the individual's all services plan, that is prior-approved by the Ohio department of medicaid (ODM) or its designee, the number of hours the provider is authorized to furnish waiver nursing services to the individual.

(g) Be identified as the provider on, and be performing nursing services pursuant to, the individual's plan of care, as that term is defined in rule 5160-45-01 of the Administrative Code. The plan of care must be signed and dated by the individual's treating physician.

(h) Be providing the service for 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.

(6) Non-agency LPNs, at the direction of an RN, must:

(a) 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 assure that waiver nursing services are being provided in accordance with the approved plan of care and within the LPN's scope of practice; and

(b) Conduct a face-to-face visit with the individual and the directing RN before initiating services and at least every one hundred 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 assure that waiver nursing services are being provided in accordance with the approved plan of care and within the LPN's scope of practice.

(7) All waiver nursing service providers must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency waiver nursing service providers must 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 must be a location other than the individual's residence. At a minimum, the clinical record must contain the information listed in paragraphs (A)(7)(a) to (A)(7)(l) of this rule.

(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 all services plans.

(e) 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 include documentation that the RN has reviewed the plans of care with the LPN. The plan of care must be recertified by the treating physician every sixty days, or more frequently if there is a significant change in the individual's condition.

(f) In all instances when the treating physician gives verbal orders to the nurse, the nurse must 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 must subsequently secure documentation of the verbal orders, signed and dated by the treating physician.

(g) In all instances when a non-agency LPN is providing waiver nursing services, the LPN must provide 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. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

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

(i) Documentation of all drug and food interactions, allergies and dietary restrictions.

(j) Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider, and the individual or the individual's authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the individual's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(k) Clinical notes signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(l) A discharge summary, signed and dated by the departing nurse, at the point the nurse is no longer going to provide services to the individual, or when the individual no longer needs nursing services. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(B) Personal care aide services.

(1) "Personal care aide services" are defined as services provided pursuant to the Ohio home care waiver's all services plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. If the individual's all services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. Personal care aide services consist of the services listed in paragraphs (B)(1)(a) to (B)(1)(e) of this rule. If the provider cannot perform IADLs, the provider must notify,

ODM or its designee, in writing, of the service limitations before inclusion on the individual's all services plan.

(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, and waste disposal;

(c) Household chores, including but not limited to washing floors, windows and walls, tacking down loose rugs and tiles; and moving heavy items to provide safe access and exit;

(d) Paying bills and assisting with personal correspondence as directed by the individual; and

(e) 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 services performed in excess of the number of hours approved pursuant to the all services plan.

(3) Personal care aides shall 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.

(4) Personal care aide services shall 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.

(5) In order to be a provider and submit a claim for reimbursement, all personal care aide service providers must meet the following:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be at least eighteen years of age.

(d) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish personal care aide services to the individual.

(e) Have a valid social security number, and one of the following forms of identification:

(i) Alien identification,

(ii) State of Ohio identification,

(iii) A valid driver's license, or

(iv) Other government-issued photo identification.

(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 foster caregiver of the individual.

(h) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit.

(i) Comply with the additional applicable provider-specific requirements as specified in paragraph (B)(6) or (B)(7) of this rule.

(6) Medicare-certified and otherwise-accredited agencies must assure that personal care aides meet the following requirements:

(a) Before commencing service delivery, the personal care aide must:

(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. 484.36 (as in effect on October 1, 2014), and

(ii) Obtain and maintain 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.

(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 must be initiated immediately, and must 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, must:

(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 must be documented in the individual's record.

(iii) Discuss the evaluation of personal care aide services with the case manager.

(d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.

(e) Be able to effectively communicate with the individual.

(7) Non-agency personal care aides must meet the following requirements:

(a) Before commencing service delivery personal care aides must 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. 484.36 (as in effect on October 1, 2014); or other equivalent training program. The program must include training in the following areas:

(a) Personal care aide services as defined in paragraph (B)(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 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.

(b) Complete twelve hours of in-service continuing education annually that must 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.

(e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.

(f) Be able to effectively communicate with the individual.

(8) All personal care aide providers must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited agencies, must maintain the clinical records at their place of business. Non-agency personal care aides must 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 must be a location other than the individual's residence. At a minimum, the clinical record must contain the information listed in paragraphs (B)(8)(a) to (B)(8)(i) of this rule.

(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 all services plans.

(e) Documentation of all drug and food interactions, allergies and dietary restrictions.

(f) A copy of any advance directives including, but not limited to, 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. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The individual or the individual's authorized representative's signature of choice shall be documented on the individual's all services plan, and shall include, but not be limited to, 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 multidisciplinary 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.

(C) 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 be a freestanding building or a space within another building that shall not be used for other purposes during the provision of ADHCS.

(a) The services the adult day health center must provide are the following:

(i) Waiver nursing services as set forth in paragraph (A) of this rule, or personal care aide services as set forth in paragraph (B)(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) The services the adult day health center may also make available include the following:

(i) Skilled therapy services as set forth in rule 5160-12-01 of the Administrative Code;

(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 (C)(1)(a) and (C)(1)(b) of this rule and delivered by an adult day health center shall not be reimbursed as separate services.

(2) ADHCS do not include 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 reimbursement, providers of ADHCS must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider on the individual's all services plan, that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish adult day health center services to the individual.

(d) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.

(4) All providers of ADHCS must:

(a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, 2014).

(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, provide documentation to ODM or its designee verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training within a twelve-month period, excluding agency and program-specific orientation, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as set forth in paragraph (B)(1) of this rule.

(f) Maintain, at all times, a 1:6 ratio of paid direct care staff to individuals.

(5) Providers of ADHCS must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record must contain the information listed in paragraphs (C)(5)(a) to (C)(5)(i) of this rule.

(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 use of technology-based systems 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 no longer 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 paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i), (A)(6)(j) and (A)(6)(k) of this rule when the individual is provided waiver nursing and/or skilled therapy services.

(D) Home delivered meal services.

(1) "Home delivered meal service" is defined as the provision of meals to an individual who has a need for a home delivered meal based on a deficit in an ADL or a deficit in an IADL identified during the assessment process. The service includes the preparation, packaging and delivery of a safe and nutritious meal(s) to an individual at his or her home. An individual may be authorized to receive up to two home delivered meals per day.

(2) Home delivered meals:

(a) Shall be furnished in accordance with menus that are approved in writing by a licensed dietitian who is currently registered with the commission on dietetic registration.

(b) Shall take into consideration the individual's medical restrictions, religious, cultural and ethnic background and dietary preferences.

(c) Shall be prepared by a provider who is in compliance with Chapters 918., 3715. and 3717. of the Revised Code, and all applicable Administrative Code rules adopted thereunder. For the purposes of this rule, reheating a prepared home delivered meal is not the same as preparing a meal.

(d) Shall be individually packaged if it is a heated meal.

(e) May be individually packaged if it is an unheated, shelf-stable meal, or may have components separately packaged, so long as the components are clearly marked as components of a single meal.

(f) May include a therapeutic diet that requires a daily amount or distribution of one or more specific nutrients in order to treat a disease or clinical condition, or eliminate, decrease or increase certain substances in the individual's diet. A therapeutic diet must be ordered by a licensed physician. A new order must be documented in the individual's clinical record every ninety days.

(3) Home delivered meals shall not:

(a) Include services or activities performed in excess of what is approved on the individual's all services plan.

(b) Supplement or replace meal preparation activities that occur during the provision of waiver nursing, personal care aide, adult day health center, home care attendant or any other similar services.

(c) Supplement or replace the purchase of food or groceries.

(d) Include bulk ingredients, liquids and other food used to prepare meals independently or with assistance. Bulk ingredients and liquids include, but are not limited to: food that must be portioned out and prepared, or any food that must be cooked or prepared.

(e) Be provided while the individual is hospitalized or is residing in an institutional setting.

(4) In order to be a provider and to submit a claim for reimbursement, all home delivered meal providers must meet all of the following requirements:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of home delivered meal services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the home delivered meal provider, and be specified, on the individual's all services plan that is prior-approved by the department or its designee.

(d) Possess any applicable current, valid license or certificate from the local health department, and retain records of all reports related to the licensure or certification.

(e) Assure that all meals are provided as identified on the individual's all services plan.

(f) Submit claims that do not exceed two meals per day per individual.

(g) Maintain documentation as set forth in paragraph (D)(8) of this rule.

(5) Home delivered meal service providers shall assure all meals, with the exception of a therapeutic diet prescribed and prepared in accordance with paragraph (D)

(2)(f) of this rule, meet the following requirements with regard to nutritional adequacy:

(a) Meet one-third of the current dietary reference intakes (DRI) established by the food and nutrition board of the institute of medicine of the national academy of sciences.

(b) Follow the current dietary guidelines for Americans as published by the U.S. department of agriculture.

(6) Home delivered meal service providers shall assure the safe delivery of meals as authorized by the department or its designee on the individual's all services plan.

(a) Ready-to-eat, temperature-controlled meals must be labeled with a preparation date. The date shall include the month, day and year the meals were prepared, and shall list, immediately adjacent to this date, the phrase "packing" or "pack date." All other meals shall be labeled with the month, day and year by which the meal shall be consumed or discarded, and shall list the date immediately following the phrase "sell by" or "use before."

(b) The provider must document evidence of a time and temperature monitoring system for food preparation, handling and delivery.

(c) The provider shall ensure all transportation vehicles and containers are safe and sanitary.

(d) When using a thermostatically-controlled meal delivery vehicle, the provider must maintain verification of testing meal temperatures no less than monthly. When using other meal delivery vehicles, the provider must maintain verification of testing meal temperatures no less than weekly.

(e) The provider must establish with the individual, and document in the individual's record, a routine date and time for meal delivery. The provider must notify the individual if delivery of the meal(s) will be delayed more than one hour past established delivery time.

(f) The provider must furnish written delivery instructions to the driver.

(g) The provider must furnish the individual or the authorized representative with clear instructions on how to safely heat or reheat each meal.

(7) Home delivered meal service providers shall assure the following with regard to training and continuing education:

(a) All personnel who participate in food preparation, food handling and/or delivery, including volunteers, must:

(i) Receive training and orientation on the following as relevant for the provider's job duties:

(a) Sensitivity to the needs of older adults and people with physical disabilities or cognitive impairments;

(b) Handling emergencies;

(c) Food storage, preparation and handling;

(d) Food safety and sanitation;

(e) Meal delivery; and

(f) Handling hazardous materials.

(ii) Successfully complete four hours of continuing education each year on the topics relevant to the provider's job duties.

(b) The provider must develop a training plan and conduct and document annual training and continuing education activities.

(8) At a minimum, home delivered meal service providers must maintain and make available, upon request, the following:

(a) A record for each individual served that contains a copy of the initial and all subsequent all services plans, all dietary orders and instructions prepared by the physician, menus approved by the dietitian, and any additional information supporting meal delivery as specified on the all services plan.

(b) Documentation that each meal complies with paragraphs (D)(5)(a) and (D)(5)(b) of this rule.

(c) Documentation of each individual's therapeutic diet as set forth in paragraph (D)(2)(f) of this rule.

(d) Documentation from the provider that the individual or the authorized representative has been furnished clear instructions about how to safely heat or reheat each meal.

(e) Documentation that verifies delivery of home delivered meals as authorized on the individual's all services plan. Documentation shall include, but

not be limited to, the individual's name, the dated signature of the home delivered meal service provider, the established delivery date and time, the actual time of delivery of all meals and the number of meals delivered, signature or initials of the person delivering the meal(s) and the signature or initials of the individual or the authorized representative receiving the meal(s). Nothing shall prohibit the collection or maintenance of documentation through technology-based systems. individual's or authorized representative's signature of choice shall be documented on the individual's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(f) Documentation that the home delivered meal delivery staff possesses a current and valid driver's license.

(g) Documentation of vehicle owner's liability insurance.

(h) Documentation that the provider has established a routine delivery time with the individual.

(i) All local health department inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.

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

(k) All U.S. department of agriculture inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.

(l) All licensure/certification documents required as a result of paragraph (D) (4) of this rule.

(9) Home delivered meal provider inspections and follow-up.

(a) Home delivered meal service providers cited for critical violations, as that term "critical violations" is used in paragraph (B) of rule 3717-1-02.4 of the Administrative Code, during their local health department inspections, shall notify ODM or its designee no more than forty-eight hours after issuance of the citation. The provider shall, within forty-eight hours, send to ODM or its designee a copy of the inspection report, any plans of correction and any follow-up reports.

(b) Home delivered meal service providers inspected by the Ohio department of agriculture division of food safety and placed on priority status or notice

status shall notify ODM or its designee no more than two business days after the issuance of the report of priority status, or after the issuance of the report of notice status in accordance with section 913.42 of the Revised Code. The provider shall, within five business days, send to ODM or its designee, a copy of the report(s) with documented findings, any notices issued by the Ohio department of agriculture, and any resulting plans of correction and follow-up reports.

(c) Home delivered meal service providers inspected by the Ohio department of agriculture division of meat inspection or the U.S. department of agriculture food safety inspection service shall notify ODM or its designee no more than two business days after it takes a withholding action against, or it suspends the provider in accordance with 9 C.F.R. 500.3 (as in effect on October 1, 2014) and/or 9 C.F.R. 500.4 (as in effect on October 1, 2014). The provider shall, within five business days, send to ODM or its designee, a copy of the action issued by the Ohio department of agriculture or the U.S. department of agriculture food safety inspection service, any resulting plans of correction and any follow-up reports.

(d) ODM may immediately suspend and terminate a provider's authorization to furnish home delivered meal services pursuant to section 5164.38 of the Revised Code and rule 5160-1-17.6 of the Administrative Code if ODM or its designee receives credible information that the provider poses a significant threat to the health and welfare of one or more individuals due to noncompliance with one or more of the requirements set forth in this rule.

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of an individual's home that enable the individual to function with greater independence in the home and remain in the community. Home modification services are not otherwise available through any other funding source and must be suitable to enable the individual to function with greater independence, avoid institutionalization and reduce the need for human assistance. They shall not exceed a total of ten thousand dollars within a twelve-month calendar year per individual. ODM or its designee shall only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

(a) The property owner must give written consent for the home modification that indicates an understanding that the Ohio home care waiver will not pay to have the property returned to its prior condition.

(b) The need for home modification services must be identified by an occupational therapist or physical therapist as licensed pursuant to sections 4755.08 and 4755.44 of the Revised Code, during an in-person evaluation of the site to be modified, and with the individual present.

(c) Home modifications include repairs of previous home modifications excluding those described in paragraph (E)(2)(e) of this rule.

(2) Home modification services do not include:

(a) Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the individual (i.e., carpeting, roof repair, central air conditioning, etc.).

(b) Adaptations that add to the total square footage of the home.

(c) Services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(d) The same type of home modification for the same individual during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the individual's medical and/or physical condition that requires the replacement.

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

(3) Home modification service providers shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the bid specification. The reimbursement may only be adjusted if the job specifications are modified in writing by ODM or its designee and the adjustment is warranted. Family members and volunteers shall meet all of the provider requirements set forth in paragraph (E) of this rule, however they shall only be reimbursed for the cost of materials.

(4) In order to be a provider and submit a claim for reimbursement, providers of home modification services must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified, on the individual's all services plan, that is prior-approved by ODM or its designee, the home modification services that the provider is authorized to furnish to the individual.

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

(e) Provide documentation that the home modification was tested and in proper working order.

(f) Provide documentation that the home modification meets all applicable state and local building codes.

(g) Provide documentation that the home modification meets the individual's needs and complies with the Americans with Disabilities Act (ADA) (as in effect on January 1, 2015), the Uniform Federal Accessibility Standards (UFAS) (as in effect on January 1, 2015) or the Fair Housing Act (FHA), (as in effect on January 1, 2015) as applicable. If a home modification must be customized in order to meet the individual's needs, and that customization will not be compliant with the ADA, UFAS or FHA, it must be prior-approved by ODM or its designee, in consultation with the individual and/or the authorized representative and the individual's interdisciplinary team.

(h) Maintain licensure, insurance and bonding for general contracting services of applicable jurisdictions and provide proof to ODM or its designee upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the individual.

(i) Obtain a final written approval from the individual and ODM or its designee after completion of the home modification service.

(5) Selection of home modification service providers.

(a) In consultation with the individual, authorized representative and/or caregiver(s), ODM or its designee shall develop job specifications based on the in-person evaluation required in paragraph (E)(1)(b) of this rule to meet the individual's environmental accessibility needs using the lowest cost alternative.

(b) At a minimum, ODM or its designee shall send the home modification specifications to every known home modification service provider in the individual's county of residence and all contiguous counties, and shall invite the submission of competitive bids. Home modification providers shall submit bids that include all of the following:

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

(ii) An itemized list of all materials needed for the home modification;

(iii) An itemized list of the cost of the materials needed for the home modification;

(iv) An itemized list of the labor costs;

(v) A written statement of all warranties provided, including at a minimum, a minimum one-year warranty for all materials and workmanship associated with the home modification; and

(vi) A written attestation that the provider, all employees and/or all subcontractors to be used to perform the job specifications have the necessary experience and skills, and meet all of the provider requirements set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(c) ODM or its designee shall review all submitted bids and the home modification service will be awarded to the lowest responsive and most responsible bidder, with price and other relevant factors being considered in the selection process.

(F) 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 be prior-approved by ODM or its designee. ODM or its designee shall 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 not exceed a combined total of ten thousand dollars within a calendar year per individual.

(b) ODM or its designee shall 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 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 downpayments 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 pursuant to, and as specified on the individual's all services plan;

(iv) New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse or negligence; and

(v) Activities described in paragraph (F)(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 must 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 (F)(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 must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the individual.

(d) Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services.

(e) Assure that 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 must 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 must contain the information listed in paragraphs (F)(4)(a) to (F)(4)(d) of this rule.

(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 all services plans.

(d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(G) Out-of-home respite services.

(1) "Out-of-home respite services" are services delivered to an individual in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.

(a) The services the out-of-home respite provider must make available are:

(i) Waiver nursing services as set forth in paragraph (A) of this rule;

(ii) Personal care aide services as set forth in paragraph (B)(1) of this rule; and

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

(b) All services set forth in paragraph (G)(1)(a) of this rule and delivered during the provision of out-of-home respite services shall not be reimbursed as separate services.

(2) Out-of-home respite services do not include 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 reimbursement, providers of out-of-home respite services must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish out-of-home respite services to the individual.

(d) Be either:

(i) An intermediate care facility for individuals with an intellectual disability (ICF-IID) licensed and certified in accordance with rules 5160-3-02 and 5160-3-02.3 of the Administrative Code; or

(ii) A nursing facility (NF) licensed and certified in accordance with rules 5160-3-02 and 5160-3-02.3 of the Administrative Code; or

(iii) Another licensed setting approved by ODM or its designee.

(e) Be providing out-of-home respite services for one individual, or for up to three individuals in a group setting on the same date.

(4) All providers of out-of-home respite services must:

(a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, 2014).

(b) 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, provide documentation to ODM or its designee verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.

(5) Providers of out-of-home respite services must maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record must contain the information listed in paragraphs (G)(5)(a) to (G)(5)(i) of this rule.

(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 all services plans.

(e) A copy of any advance directives 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 out-of-home respite service delivery, including tasks performed or not performed. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing out-of-home respite service provider, at the point the service provider is no longer going to provide services to the individual, or when the individual no longer needs out-of-home respite services. 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 paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i), (A)(6)(j) and (A)(6)(k) of this rule when the individual is provided waiver nursing.

(H) Emergency response services.

(1) "Emergency response services (ERS)" are emergency intervention services composed of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the individual and the emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment.

(2) ERS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with the individual's specific needs. All ERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:

(a) Wearable waterproof activation devices;

(b) Devices that offer:

(i) Voice-to-voice communication capability,

(ii) Visual indication of an alarm that may be appropriate if the individual is hearing impaired, or

(iii) Audible indication of an alarm that may be appropriate if the individual is visually impaired;

(3) ERS does not include the following:

(a) Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment.

(b) In-home communication connection systems used to supplant routine supervision of individuals who are under the age of eighteen.

(c) Remote monitoring services.

(d) Services performed in excess of what is approved pursuant to the individual's all services plan.

(e) New equipment or repair of previously approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence.

(4) In order to be a provider and submit a claim for ERS, the provider must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-04 of the Administrative Code.

(c) Be identified as the provider, and have specified on the individual's all services plan, the ERS that the provider is authorized to furnish.

(5) ERS provider requirements.

(a) Providers shall assure that all individuals are able to choose the ERS equipment that meets their specific needs as set forth on their all services plan.

(b) Providers shall furnish each individual receiving ERS with an initial face-to-face demonstration and training on how to use their ERS equipment. Additional training shall be provided to designated responders as part of the monthly service in accordance with paragraph (H)(5)(c) of this rule, and to the individual, caregiver and ODM or its designee upon request.

(c) Before, or during the delivery of ERS equipment, the provider shall work with the individual and/or the authorized representative, and the case manager to develop a written response plan regarding how to proceed in the event the ERS signals an alarm. The written response plan shall be updated as often as desired by the individual and/or the authorized representative, but shall be reviewed no less than every six months.

(i) The written response plan shall include a summary of the individual's health history and functioning level, as well as the name of, and contact information for, at least one individual who will serve as

the individual's designated responder. If the individual identifies more than one designated responder, he or she shall also indicate the order in which the responders should be contacted. For the purposes of this rule, "designated responder" means a person or persons who the individual and/or his or her authorized representative chooses to be contacted by the ERS provider in the event the ERS signals an alarm. If fewer than two individuals are designated as responders, then emergency service personnel shall be designated as responders in the plan.

(ii) The provider shall furnish initial training to all designated responders before activation of the individual's ERS equipment, and on an annual basis. At a minimum, the training shall include:

(a) Instruction regarding how to respond to an emergency, including how to contact emergency service personnel; and

(b) Distribution of written materials regarding how to respond to an ERS signal.

(iii) The provider shall work with the individual and/or the authorized representative, and the case manager to revise the written response plan when there is a change in designated responders.

(a) If the individual has only one designated responder, the provider shall secure a replacement within four days after notification of the change, and document this change in the plan.

(b) If the individual has two or more designated responders, the provider shall secure a replacement responder within seven days after notification of the change, and document this change in the plan.

(c) If the provider is unable to secure a replacement responder within the required time period, then the provider shall notify the case manager, and emergency service personnel shall be designated as the responder in the plan.

(iv) In the event the individual sends a signal but a designated responder cannot be reached, the provider shall contact emergency service personnel and shall remain on the line until emergency service personnel arrive on the scene of the emergency.

(d) Providers shall assure that emergency response centers:

(i) Employ and train staff to receive and respond to signals from individuals twenty-four hours per day, three hundred sixty-five days per year.

(ii) Maintain the capacity to respond to all alarm signals.

(iii) Maintain a secondary capacity to respond to all incoming signals in case the primary system is unable to respond to alarm signals.

(iv) Respond to each alarm signal within sixty seconds of receipt.

(v) Notify ODM or its designee of all emergencies involving an individual within twenty-four hours.

(vi) Conduct monthly testing of ERS equipment to assure proper operation.

(vii) Replace, within twenty-four hours of notification and at no cost to the individual, or ODM or its designee, malfunctioning ERS equipment that has not been damaged as a result of confirmed misuse, abuse or negligence.

(viii) Replace, at no cost to the individual, or ODM or its designee, no more than one ERS pendant per year.

(ix) Operate all ERS communication lines free of charge.

(6) At a minimum, providers of ERS must maintain the documentation set forth in paragraphs (H)(6)(a) to (H)(6)(h) of this rule. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(a) A log containing the name and contact information of each individual, and his or her authorized representative.

(b) A copy of the individual's all services plan.

(c) All records necessary and in such form so as to fully disclose the extent of ERS provided and significant business transactions pursuant to rule 5160-1-17.2 of the Administrative Code.

(d) Documentation of all individual, designated responder and ERS provider training that is required pursuant to paragraph (H)(5) of this rule.

(e) A written record of the date of delivery and installation of the ERS equipment, with the individual's or authorized representative's signature verifying delivery and installation. The individual's or authorized representative's signature of choice shall be documented on the all services plan and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(f) A written record of the monthly testing conducted on each individual's ERS equipment including date, time and results of the test.

(g) A record of each service-related contact with the individual including, but not limited to, the date and time of the contact, a summary of the incident, the service delivered (including the service of responding to a false alarm), and the name of each person having contact with the individual.

(h) A copy of the individual's written response plan as set forth in paragraph (H)(5)(c) of this rule.

(I) 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 all services plan. 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) In order to be a provider and submit a claim for supplemental transportation services, the provider must:

(a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified on the individual's all services plan that is prior-approved by ODM or its designee, the amount

of supplemental transportation services the provider is authorized to furnish to the individual.

(4) Agency supplemental transportation service providers must:

(a) Maintain a current list of drivers.

(b) Maintain documentation that 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:

(i) Is not provided solely through the internet;

(ii) Includes hands-on training provided by a certified first aid instructor; and

(iii) Requires the individual to perform a successful return demonstration of what was learned in the course.

(g) Assure that 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) Assure that drivers are not the individual's foster caregivers.

(5) Non-agency supplemental transportation service providers must:

(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) Obtain and maintain a certificate of completion of a course in first aid that:

(i) Is not provided solely through the internet;

(ii) Includes hands-on training provided by a certified first aid instructor; and

(iii) Requires the individual to perform 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.

(6) All supplemental transportation service providers must 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 be documented on the individual's all services plan and shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

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

TO BE RESCINDED

5160-46-04.1 **Ohio home care waiver program: 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 the Ohio home care waiver with self-administration of medication, nursing tasks, or both. The individual, the authorized representative, legally responsible family member, legal guardian and foster caregiver are prohibited from being the authorizing health care professional.

(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), 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 (F) of this rule, who is authorized to provide home care attendant services to a specific individual enrolled on the Ohio home care waiver.

(10) "Individual enrolled on the Ohio home care waiver" and "individual receiving services" 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 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.

(15) "Oral medication" means any medication that can be administered through the mouth, or 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.

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

(17) "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.

(18) "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 (F)(15) of this rule.

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

(20) "Topical medication" means any medication that is 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 the Ohio home care waiver by an unlicensed non-agency provider in accordance with this rule. Home care attendant services include, but are not limited to, 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 (D) of this rule.

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

(3) Tasks performed as part of personal care aide services as described in paragraph (B)(1) of rule 5160-46-04 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) If the individual has an authorized representative, the authorized representative shall be present and awake during the delivery of home care attendant services.

(D) Assistance with self-administration of medication.

(1) A home care attendant shall assist an individual enrolled on the Ohio home care 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 be maintained in its original container and the attached label shall match the dosage and means of administration set forth on the ODM 02389 "Home Care Attendant Medication Authorization" form (7/2014). The label on the container shall display all of the following information for the individual enrolled on the Ohio home care 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 have a warning label on the bottle;

(b) The home care attendant shall count the medication(s) in the presence of the individual enrolled on the Ohio home care waiver or the authorized representative and shall record the count on a log located in the individual's clinical record.

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

(i) The medication(s) is missing; or

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

(d) The medication(s) shall 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 individuals.

(E) Assistance with the performance of nursing tasks.

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

(2) A home care attendant shall 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 (D)(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 (D)(1)(d) of this rule;

(f) Insertion or initiation of infusion therapies; and

(g) Central line dressing changes.

(3) Performance of nursing tasks shall be summarized and submitted on the ODM 02390 "Home Care Attendant Skilled Task Authorization" form (7/2014).

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

(1) Be at least eighteen years of age.

(2) As part of the medicaid provider agreement application process, provide ODM with evidence to its satisfaction of the following:

(a) Submission of the ODM 02389 "Home Care Attendant Medication Authorization" form (7/2014) and/or ODM 02390 "Home Care Attendant Skilled Task Authorization" form (7/2014) as prescribed by paragraph (G) of this rule.

(b) Meeting the personnel qualifications specified in 42 C.F.R. 484.4 (as in effect on October 1 2014) for home health aides, or successfully completing at least one of the following:

(i) 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

(ii) A training program approved by ODM that includes training in at least all of the following and provides training equivalent to a training and competency evaluation program specified in paragraph (F)(2)(b)(i) of this rule, or meets the requirements of 42 C.F.R. 484.36(a) (as in effect on October 1, 2014):

(a) Basic home safety;

(b) 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 of broken;

(c) Personal care aide services that are specific to the individual receiving services; and

(d) The labeling, counting and storage requirements for schedule II, schedule III, schedule IV and schedule V medications.

(c) Completion of training and instruction, prior to beginning home care attendant services, about how to deliver the specific home care attendant services authorized by the individual's authorizing health care professional. The training shall be specific to the individual enrolled on the Ohio home care waiver and may be provided by the individual's authorizing health care professional, and/or 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 (7/2014) and/or ODM 02390 "Home Care Attendant Skilled Task Authorization" form (7/2014), 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 the Ohio home care waiver or the authorizing health care professional.

(e) Completion of a course in first aid that:

(i) Is not provided solely through the internet;

(ii) Includes hands-on training provided by a certified first aid instructor;

(iii) Requires the individual to perform a successful return demonstration of what was learned in the course; and

(iv) Includes certification that education was received from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.

(3) Be a non-agency provider who holds a current, valid medicaid provider agreement as a home care attendant and complies with sections 5166.30 to 5166.3010 of the Revised Code and rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.

(4) Request reimbursement for the provision of home care attendant services in accordance with rule 5160-46-06.1 of the Administrative Code.

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

(9) Be identified as the provider, and have specified on the individual's all services plan that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish home care attendant services to the individual enrolled on the Ohio home care waiver.

(10) Have a valid social security number, and one of the following forms of identification:

(a) Alien identification;

(b) State of Ohio identification;

(c) A valid driver's license; or

(d) Other government-issued photo identification.

(11) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.

(12) Be able to effectively communicate with the individual receiving services.

(13) Provide home care attendant services for only one individual, unless authorized to provide services in a group setting in accordance with paragraph (F)(14) of this rule.

(14) If authorized, provide services to two or three individuals enrolled on the Ohio home care waiver in a group setting. Authorization on a case-by-case basis is subject to approval based on a clinical review conducted by ODM in consultation with the individual receiving services, the authorized representative, authorizing health care professional, case 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 and the ability to assure the health and welfare of the individuals enrolled on the Ohio home care waiver served by the home care attendant.

(15) Secure the services of an RN, with agreement of the individual receiving services and participate in a face-to-face visit at least every ninety days with the individual receiving services and the RN for the purpose of answering any

questions the home care attendant and/or individual receiving services have about meeting care needs, medications and other issues.

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

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

(ii) Possess an active Ohio medicaid provider agreement;

(iii) Be identified on the approved all services plan of the individual receiving services; and

(iv) Comply with the conditions of participation as set forth in rule 5160-45-10 of the Administrative Code.

(b) The first visit between the home care attendant and the RN shall occur upon the initiation of home care attendant services. The case manager shall also be present at the first visit.

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

(d) The home care attendant shall discuss the results of the RN home care attendant service visit with the case manager and the individual receiving services and/or the authorized representative.

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

(16) Completion of at least twelve hours of in-service continuing education regarding home care attendant services annually. Evidence of completion must be submitted to ODM no later than the annual anniversary of the issuance of the home care attendant's initial medicaid provider agreement. Continuing education topics include, but are not limited to, health and welfare, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings and mental health issues.

(G) The ODM 02389 "Home Care Attendant Medication Authorization" form (7/2014) and/or the ODM 02390 "Home Care Attendant Skilled Task Authorization" form (7/2014), as appropriate, shall contain all of the following:

(1) Written consent from the individual enrolled on the Ohio home care 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.

(2) Written statement from the authorizing health care professional attesting that the individual enrolled on the Ohio home care waiver or the authorized representative has demonstrated the ability to direct the home care attendant. The written statement shall also indicate whether the home care attendant has demonstrated the ability to furnish the home care attendant service to the individual enrolled on the Ohio home care waiver. The statement shall 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 must 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 fax 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 must follow when assisting the individual receiving services with the performance of a nursing task or the self-administration of medications, including, but not limited to,

instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies.

(H) The individual enrolled on the Ohio home care waiver shall:

(1) Choose to receive home care attendant services from a non-agency provider.

(2) Upon initiation of services, participate with the case manager in the development and maintenance of a written back-up plan. The authorizing health care professional and/or the home care attendant may also participate in the development and maintenance of the back-up plan.

(a) The back-up plan shall meet the needs of the individual enrolled on the Ohio home care waiver in the event:

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

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

(b) As authorized by the case manager,

(i) Waiver nursing as set forth in rule 5160-46-04 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 provide assistance with self-administration of medications and the performance of nursing tasks;

(ii) 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; and

(iii) Back-up may include informal caregivers.

(I) All home care attendants must maintain a clinical record for each individual served in a manner that protects the confidentiality of the record and for the purpose of contributing to the continuity of the individual's care. Home care attendants must maintain the clinical records at their place of business, and maintain a copy in the home of the individual receiving services. The individual shall identify a location in his or her residence where a copy of the clinical record will be safely maintained. The clinical records must contain the following information:

(1) Identifying information including, but not limited to, name, address, age, date of birth, sex, race, marital status, significant phone numbers and health identification numbers for the individual.

(2) The medical history of the individual.

(3) The name of, and contact information for all of the licensed health care professionals serving the individiual.

(4) A copy of the initial and all subsequent all services plans.

(5) Documentation of all drug and food interactions, allergies and dietary restrictions.

(6) 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.

(7) The ODM 02389 "Home Care Attendant Medication Authorization" form (7/2014) and/or an ODM 02390 "Home Care Attendant Skilled Task Authorization" form (7/2014), as appropriate.

(8) 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 be documented on the all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(9) 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.

(10) Progress notes signed and dated by the home care attendant, documenting all communications with the case manager, health care professionals including the authorizing health care professional, and other members of the individual's team, and documenting any unusual events occurring during the visit, and the general condition of the individual enrolled on the Ohio home care waiver.

(11) Documentation of the face-to-face RN home care attendant service visits every ninety days between the home care attendant, individual enrolled on the Ohio home care waiver and RN, and of any resulting activities, in accordance with paragraph (F)(15) of this rule.

(12) A discharge summary, signed and dated by the departing home care attendant at the point the home care attendant is no longer going to provide services, or when the individual enrolled on the Ohio home care waiver no longer wants or needs home care attendant services. The summary should include documentation regarding progress made toward achievement of goals as specified on the all services plan and indicate any recommended follow-ups or referrals.

(J) If ODM or its designee determines that the individual enrolled on the Ohio home care waiver cannot meet the requirements of this rule, or the health and welfare of the individual receiving home care attendant services cannot be assured, then ODM or its designee may prohibit the individual from receiving home care attendant services. The individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(K) A home care attendant who provides home care attendant services to an individual enrolled on the Ohio home care waiver in accordance with the limitations set forth in this rule, including activities in accordance with the authorizing health care professional's authorizaiton, shall not be considered to be engaging in the practice of nursing as an RN or an LPN in violation of section 4723.03 of the Revised Code.

(1) The individual who is receiving home care attendant services or a provider shall report to ODM all instances in which a home care attendant appears to have:

(a) Provided nursing services, other than assistance with self-administration of medication or the performance of nursing tasks as authorized in this rule; or

(b) Provided services not in accordance with the authorizing health care professional's authorization.

(2) ODM may initiate an investigation based on the report, and shall report its findings to the Ohio board of nursing.

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