OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

To: ALL CLEARANCE REVIEWERS
From: Sara Abbott, Chief, Bureau of Long Term Care Services and Supports
Date: March 22, 2010
Subject: **Amendment of ODJFS-administered Waiver Program Provider Rules**

Attached for your review and comment are draft rules 5101:3-45-01, 5101:3-45-03, 5101:3-45-10, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04 of the Administrative Code which are being proposed for amendment. Also attached is a draft community services transmittal letter that will accompany the rules following their promulgation. These rules set forth the program definitions, consumer choice options, provider conditions of participation, and service specifications and provider requirements governing the Ohio Home Care, Transitions DD and Transitions Carve-Out Waivers.

OAC Rule 5101:3-45-01, ODJFS-administered Waiver Program: Definitions, contains key definitions associated with ODJFS-administered waivers. Among the changes are the following:

- The definition of "assurance of health and welfare agreement" is being deleted and replaced with "consumer acknowledgement of risk agreement" to reflect changes in the form used to remedy risks to consumers' health and welfare.
- The definition of "family member" is being removed because that term, as it is used in the Transitions DD Waiver, is being modified to only refer to the legally responsible family member. Likewise, "legally responsible family member" and "non-legally responsible family member" are being amended. With these changes, non-legally responsible family members will be able to be paid providers of personal care aide services, home modification services, supplemental transportation services and waiver nursing services.
- Other definitions are being modified to correct terminology and/or offer additional clarity.

OAC Rule 5101:3-45-03, ODJFS-administered Waiver Program: Consumer Choice and Control, sets forth the extent to which a consumer enrolled on an ODJFS-administered waiver has choice and control over the arrangement/direction of his/her home and community-based waiver services, and the selection and control over the direction of the providers of those services. The rule is being amended in order to add the new home care attendant provider to the definition of "non-agency provider." It is also being amended to update OAC rule cites, and to clarify that if a consumer and/or authorized representative chooses to receive waiver services from a non-agency provider, the consumer and/or authorized representative shall work with the case management agency and the non-agency provider to identify and secure continuing education within the non-agency provider's scope of practice. The consumer may participate in or conduct the continuing education.

OAC Rule 5101:3-45-10, Conditions of Participation for Ohio Department of Jobs and Family Services (ODJFS) administered Waiver Service Providers, contains the core conditions of participation that a provider must meet in order to furnish ODJFS-administered waiver services. The existing rule is being rescinded and replaced with a new rule bearing the same number. The rule is being reorganized for clarity and to make reference to new rule cites. Most changes are nonsubstantive.

OAC Rule 5101:3-46-04, Ohio Home Care Waiver Program: Definitions of the Covered Services and Provider Requirements and Specifications, 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. Among other things,

- The rule is being amended to clarify the service-specific requirements an agency or individual must meet in order to be a provider and to submit a claim for reimbursement under the Ohio Home Care Waiver.
- Home delivered meal services and emergency response services are being amended to make them consistent with the service specifications and provider requirements recently developed by ODJFS, the Ohio Department of Aging and the Ohio Department of Developmental Disabilities under the advisement of the Executive Medicaid Management Agency (EMMA). These service specifications and provider requirements will be adopted by each state agency when such services are added or amended.

OAC Rule 5101:3-47-04, Transitions DD Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Transitions DD Waiver. Like OAC rule 5101:3-46-04, this rule sets forth the provider requirements and specifications for the delivery of waiver services. The changes are the same as in OAC rule 5101:3-46-04, but they also include the following:

- References to the Transitions MR/DD Waiver are being removed and replaced with Transitions DD Waiver to reflect the change in terminology that has been embraced statewide.
- Non-legally-responsible family members will be permitted to be paid providers of personal care aide services, home modification services, supplemental transportation services and waiver nursing services.

OAC Rule 5101:3-50-04, Transitions Carve-Out Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Transitions Carve-Out Waiver. Like OAC rules 5101:3-46-04 and 5101:3-47-04, this rule sets forth the provider requirements and specifications for the delivery of waiver services. The changes are the same as those affecting the Ohio Home Care Waiver.

Thank you in advance for your comments.

Attachments

Ohio | Department of Job and Family Services

Ted Strickland, Governor
Douglas E. Lumpkin, Director

Community Services Transmittal Letter (CSTL) No. 10-xx

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Amendment of ODJFS-administered Waiver Program Provider Rules

The Ohio Department of Job and Family Services (ODJFS) has amended rules 5101:3-45-01, 5101:3-45-03, 5101:3-45-10, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04 of the Administrative Code. These rules set forth the program definitions, consumer choice options, provider conditions of participation, and service specifications and provider requirements governing the Ohio Home Care, Transitions DD and Transitions Carve-Out Waivers. They became effective on XX/XX/2010.

OAC Rule 5101:3-45-01, ODJFS-administered Waiver Program: Definitions, contains key definitions associated with ODJFS-administered waivers. Among the changes are the following:

- The definition of "assurance of health and welfare agreement" has been deleted and replaced with "consumer acknowledgement of risk agreement" to reflect changes in the form used to remedy risks to consumers' health and welfare.
- The definition of "family member" has been removed because that term, as it is used in the Transitions DD Waiver, has been modified to only refer to the legally responsible family member. Likewise, "legally responsible family member" and "non-legally responsible family member" have been amended. With these changes, non-legally responsible family members will be able to be paid providers of personal care aide services, home modification services, supplemental transportation services and waiver nursing services.
- Other definitions have been modified to correct terminology and/or offer additional clarity.

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- The rule has been amended to clarify the service-specific requirements an agency or individual must meet in order to be a provider and to submit a claim for reimbursement under the Ohio Home Care Waiver.

- Home delivered meal services and emergency response services have been amended to make them consistent with the service specifications and provider requirements recently developed by ODJFS, the Ohio Department of Aging and the Ohio Department of Developmental Disabilities under the advisement of the Executive Medicaid Management Agency (EMMA). These service specifications and provider requirements will be adopted by each state agency when such services are added or amended.

OAC Rule 5101:3-47-04, Transitions DD Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Transitions DD Waiver. Like OAC rule 5101:3-46-04, this rule sets forth the provider requirements and specifications for the delivery of waiver services. The changes are the same as in OAC rule 5101:3-46-04, but they also include the following:

- References to the Transitions MR/DD Waiver have been removed and replaced with Transitions DD Waiver to reflect the change in terminology that has been embraced statewide.
- Non-legally-responsible family members will be permitted to be paid providers of personal care aide services, home modification services, supplemental transportation services and waiver nursing services.

OAC Rule 5101:3-50-04, Transitions Carve-Out Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Transitions Carve-Out Waiver. Like OAC rules 5101:3-46-04 and 5101:3-47-04, this rule sets forth the provider requirements and specifications for the delivery of waiver services. The changes are the same as those affecting the Ohio Home Care Waiver.

Instructions:

Remove as Obsolete	**Insert Replacement**
5101:3-45-01 (effective 10/25/2009)	5101:3-45-01 (effective XX/XX/2010)
5101:3-45-03 (effective 08/13/2007)	5101:3-45-03 (effective XX/XX/2010)
5101:3-45-10 (effective 08/01/2005)	5101:3-45-10 (effective XX/XX/2010)
5101:3-46-04 (effective 07/01/2006)	5101:3-46-04 (effective XX/XX/2010)
5101:3-47-04 (effective 07/01/2006)	5101:3-47-04 (effective XX/XX/2010)
5101:3-50-04 (effective 07/01/2006)	5101:3-50-04 (effective XX/XX/2010)

Web Pages:
The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

This transmittal letter and attachments may be viewed as follows:
(1) Select "Ohio Health Plans – Provider" (right column).
(2) Select "Ohio Home Care" (left column).

(3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:
Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

5101:3-45-01 **ODJFS-administered waiver program: definitions.**

(A) "Accreditation commission for health care (ACHC)" is a national organization that evaluates and accredits home health agencies seeking to participate in the medicare and medicaid programs.

(B) "Activities of daily living" are personal or self-care skills performed on a regular basis, with or without the use of adaptive and assistive devices that enable a consumer to meet basic life needs for food, hygiene and appearance as defined in rule 5101:3-3-06 of the Administrative Code.

(C) "Agency-consumer agreement" means the ODJFS-approved agreement signed by the consumer and/or authorized representative and the case manager (CM) that assures that the consumer is voluntarily enrolling in an ODJFS-administered waiver as an alternative to receiving services in a facility or hospital. It identifies the conditions and responsibilities a waiver consumer must agree to as a condition of enrollment.

(D) "Agency provider" is a provider that is eligible to participate in the medicaid program upon execution of a medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code.

(E) "All services plan" is the service coordination and payment authorization document that identifies specific goals, objectives and measurable outcomes for consumer health and functioning expected as a result of services provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the consumer.

(1) At a minimum, the all services plan shall include:

(a) Essential information needed to provide care to the consumer that assures the consumer's health and welfare;

(b) Billing authorization; and

(c) Signatures indicating the consumer's acceptance or rejection of the all services plan.

(2) The all services plan is not the same as the physician's plan of care.

(F) "Applicant" is a person who completes a JFS 02399 "Request for Medicaid Home and Community-Based Services" (rev. 1/2006) and submits it to the county department of job and family services (CDJFS) requesting an eligibility determination for an ODJFS-administered waiver.

(G) "Assessment" is a comprehensive face-to-face evaluation conducted as part of the ODJFS-administered waiver program eligibility determination/redetermination process. It is an evaluation of a person's living arrangements/ household composition, medical and acute/long term care history, medical interventions and treatment regimens, medication profile, functional ability, psycho-social status, safety and cognition status, environmental situation, usage of adaptive and assistive equipment, informal supports and caregiver involvement, and formal supports, and results in a level of care recommendation.

~~(H) "Assurance of health and welfare agreement" is the document created between the designated case management agency (CMA) and the consumer identifying and setting forth the interventions mutually agreed upon by the consumer and CM to promote the health and welfare of the ODJFS-administered waiver consumer.~~

~~(I)~~(H) "Authorized representative" is a person the waiver applicant or consumer identifies in writing to ~~the designated CMA~~ ODJFS or its designee as a person who will act on his or her behalf for specifically identified purposes. The authorized representative shall not be the consumer's ODJFS-administered waiver service provider.

~~(J)~~(I) "Case management agency (CMA)" is the ~~ODJFS-designated entity that provides~~ entity designated by ODJFS to provide case management services to consumers enrolled on an ODJFS-administered waiver.

~~(K)~~(J) "Case management services" are the administrative activities that link, coordinate and monitor the services and resources provided to a consumer enrolled on an ODJFS-administered waiver. ODJFS may designate other entities to perform one or more of these functions.

~~(L)~~(K) "Case manager" is a registered nurse (RN), licensed social worker (LSW) or licensed independent social worker (LISW) employed by the CMA who provides case management services to consumers enrolled on an ODJFS-administered waiver.

~~(M)~~(L) "CDJFS" is a county department of job and family services.

~~(N)~~(M) "Clinical record" is a record containing written documentation that must be maintained by each ODJFS-administered waiver service provider.

~~(O)~~(N) "CMS" is the federal centers for medicare and medicaid services.

~~(P)~~(O) "Community health accreditations program (CHAP)" is a national organization that evaluates and accredits home health agencies seeking to participate in the medicare and medicaid programs. For the purpose of providing services to ODJFS-administered waiver consumers, CHAP-accredited agencies are "otherwise-accredited agencies" that may provide the same ODJFS-administered waiver services that ACHC-accredited and joint commission-accredited agencies provide.

~~(Q)~~(P) "Consumer" is an applicant determined financially eligible for medicaid and program-eligible for an ODJFS-administered waiver who is enrolled on an ODJFS-administered waiver.

(Q) "Consumer acknowledgement of risk agreement" is the document created between ODJFS or its designee and the consumer identifying and setting forth the interventions recommended by the case manager to remedy risks to the consumer's health and welfare.

(R) "Event-based assessment" is a face-to-face comprehensive evaluation of an ODJFS-administered waiver consumer as warranted by a significant change experienced by that consumer.

~~(S) "Family member" as that term is used in the transitions MR/DD waiver set forth in Chapter 5101:3-47 of the Administrative Code, is a consumer's or provider's immediate relative or member of the family, including:~~

~~(1) Husband or wife;~~

~~(2) Birth or adoptive parent, child or sibling;~~

~~(3) Stepparent, stepchild, stepbrother, stepsister, half-brother, or half-sister;~~

~~(4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;~~

~~(5) Grandparent or grandchild; or~~

~~(6) Spouse of grandparent or grandchild.~~

~~(T)~~(S) "Formal services" are paid services provided to a consumer regardless of funding source. Formal services include, but are not limited to, medicare, private insurance, third party insurance, and community-funded services such as those funded by county boards of mental retardation and developmental disabilities (CBMR/DD).

~~(U)~~(T) "Group rate" is the amount that certain waiver ~~nursing and personal care aide~~ service providers are reimbursed when the service is provided in a group setting. When providing services in a group setting, the provider must bill using the HQ modifier as described in rule 5101:3-46-06, 5101:3-47-06 or 5101:3-50-06 of the Administrative Code, as applicable.

~~(V)~~(U) "Group setting" is a situation ~~where a waiver nursing and/or personal care aide~~ in which certain service providers ~~furnishes~~ furnish the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of ODJFS-administered waiver service, or a combination of

ODJFS-administered waiver services and similar non-ODJFS-administered waiver services.

~~(W)~~(V) "Health and welfare" is a requirement imposed by CMS whereby ODJFS must assure that necessary safeguards are taken to protect the health and welfare of ODJFS-administered waiver consumers. CMS will not grant an ODJFS-administered waiver, and may terminate an existing ODJFS-administered waiver, if ODJFS fails to assure compliance with this requirement. ODJFS meets this requirement, at a minimum, by implementing policies and procedures regarding the following:

(1) Consumer risk and safety planning and evaluations;

(2) Consumer critical incident management;

(3) Housing and environmental safety evaluations;

(4) Consumer behavioral interventions;

(5) Consumer medication management; and

(6) Natural disaster and public emergency response planning.

~~(X)~~(W) "ICF-MR level of care" is the institutional level of care set forth in rule 5101:3-3-07 of the Administrative Code.

~~(Y)~~(X) "Individual cost cap" is the monthly cost of services that is approved by ODJFS for a consumer enrolled in the "Ohio Home Care Waiver," "Transitions ~~MR/DD~~ DD Waiver" or "Transitions Carve-Out Waiver." ODJFS~~, or at its direction, the CMA,~~ - or its designee oversees that the cost of covered services does not exceed the individual cost cap, determines when an increase or decrease in the cap is required, and makes a recommendation with justification to ODJFS for approval for increasing or decreasing the individual cost cap.

~~(Z)~~(Y) "Informal services" are unpaid services provided to a consumer.

~~(AA)~~(Z) "Institutional level of care" is any of the levels of care set forth in rules 5101:3-3-05, 5101:3-3-06 and 5101:3-3-07 of the Administrative Code.

~~(BB)~~(AA) "Institutional setting" is any nursing facility (NF), intermediate care facility for the mentally retarded/developmentally disabled (ICF-MR) or hospital.

~~(CC)~~(BB) "Instrumental activity of daily living" is a community living skill performed on a regular basis, with or without the use of adaptive and assistive devices, that enables a consumer to independently manage his or her living arrangement as defined in rule 5101:3-3-08 of the Administrative Code.

~~(DD)~~(CC) "Intermediate level of care (ILOC)" is the institutional level of care set forth in rule 5101:3-3-06 of the Administrative Code.

~~(EE)~~(DD) "Joint commission" is a national organization that evaluates and accredits home health agencies that seek to participate in the medicare and medicaid programs. For the purpose of providing services to ODJFS-administered waiver consumers, joint commission-accredited agencies are "otherwise-accredited agencies" that may provide the same ODJFS-administered waiver services that ACHC-accredited and CHAP-accredited agencies provide.

~~(FF)~~(EE) "Legally responsible family member," as that term is used in the Ohio home care waiver set forth in Chapter 5101:3-46 of the Administrative Code, the transitions DD waiver set forth in Chapter 5101:3-47 of the Administrative Code, and the transitions carve-out waiver set forth in Chapter 5101:3-50 of the Administrative Code, is a consumer's spouse, or in the case of a minor, the consumer's birth or adoptive parent, or foster caregiver.

~~(GG)~~(FF) "Medical necessity" and "medically necessary" have the same meaning as set forth in rule 5101:3-1-01 of the Administrative Code.

~~(HH)~~(GG) "Medicare-certified home health agency" is any entity, agency or organization that has and maintains medicare certification as a home health agency, and is eligible to participate in the medicaid program upon execution of a medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code.

~~(II)~~(HH) "Non-agency waiver service provider" is an independent provider who is not employed by an agency, and who is eligible to participate in the medicaid program upon execution of a medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code.

~~(JJ)~~(II) "Noninstitutional setting" is any setting that is not a NF, ICF-MR or hospital.

~~(KK)~~(JJ) "Non-legally responsible family member," as that term is used in the Ohio home care waiver set forth in Chapter 5101:3-46 of the Administrative Code, the transitions DD waiver set forth in Chapter 5101:3-47 of the Administrative Code, and the transitions carve-out waiver set forth in Chapter 5101:3-50 of the Administrative Code, is a member of the consumer's family, excluding the consumer's spouse, or in the case of a minor, the consumer's birth or adoptive parent, or foster caregiver.

~~(LL)~~(KK) "ODJFS" is the Ohio department of job and family services.

~~(MM)~~(LL) "ODJFS-administered waiver program" is the Ohio home care program benefit package that consists of home and community-based service waivers administered by ODJFS in accordance with Chapter 5101:3-45 of the

Administrative Code, and Chapter 5101:3-46, 5101:3-47 and/or 5101:3-50 of the Administrative Code, as applicable.

~~(NN)~~(MM) "ODJFS-administered waiver provider" is an agency or non-agency provider eligible to provide ODJFS-administered waiver services upon execution of a medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code.

~~(OO)~~(NN) "Ohio Home Care Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

~~(PP)~~(OO) "Otherwise-accredited agency" is an agency that has and maintains accreditation by a national accreditation organization for the provision of home health services, private duty nursing, personal care services and support services upon execution of a medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. The national accreditation organization shall be approved by CMS, and shall include, but not be limited to: ACHC, CHAP and the joint commission.

~~(QQ)~~(PP) "Program eligibility assessment tool (PEAT)" is the ODJFS-developed tool used during a face-to-face interview with an applicant or consumer as part of the ODJFS-administered waiver program eligibility determination/redetermination process.

~~(RR)~~(QQ) "Plan of care" is the medical treatment plan that is established, approved and signed by the treating physician. The plan of care must be signed and dated by the treating physician prior to requesting reimbursement for a service. It must include the name(s) of all of the agency and nonagency providers who are working under that plan of care. The plan of care is not the same as the all services plan.

~~(SS)~~(RR) "Request for Medicaid Home and Community-Based Services" and "JFS 02399 Request for Medicaid Home and Community-Based Services" mean the form an applicant must complete and submit to the CDJFS requesting an eligibility determination for enrollment in an ODJFS-administered waiver

~~(TT)~~(SS) "Residential address" is any physical dwelling with a unique mailing address where an ODJFS-administered waiver consumer lives. A residential address shall include, but is not limited to an apartment within an apartment complex. It shall not include the entire apartment building or complex.

~~(UU)~~(TT) "Significant change" is a change experienced by a consumer that warrants an event-based assessment. Significant changes include, but are not limited to, a change in health status, caregiver status, and location/residence; referral to or active involvement on the part of a protective service agency; institutionalization; and when the consumer has not received waiver services for ninety calendar days.

~~(VV)~~(UU) "Skilled level of care (SLOC)" is the institutional level of care set forth in rule 5101:3-3-05 of the Administrative Code.

~~(WW)~~(VV) "Transitions Carve-Out Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.

~~(XX)~~(WW) "Transitions ~~MR/DD~~ DD Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with Chapters 5101:3-45 and 5101:3-47 of the Administrative Code.

5101:3-45-03 **ODJFS-administered waiver program: consumer choice and control.**

Consumers enrolled on an Ohio department of job and family services- (ODJFS) administered waiver in accordance with rule 5101:3-46-02, 5101:3-47-02 or 5101:3-50-02 of the Administrative Code, and/or their authorized representatives, have choice and control over the arrangement and provision of home and community-based waiver services. Consumers also have choice over the selection and control over the direction of approved waiver service providers.

(A) An ODJFS-administered waiver service provider is categorized as either an "agency provider" or a "non-agency provider."

(1) An "agency provider" means a medicare-certified home health agency, an otherwise-accredited agency as defined in rule 5101:3-45-01 of the Administrative Code or other approved ODJFS-administered waiver service provider.

(2) A "non-agency provider" means an RN, an LPN at the direction of an RN, ~~or~~ a non-agency personal care aide service provider, or a non-agency home care attendant.

(B) A consumer may choose to receive waiver services as follows:

(1) Exclusively from agency providers;

(2) Exclusively from non-agency providers; or

(3) From a combination of agency and non-agency providers.

(C) The case management agency (CMA) shall assure that consumers and/or their authorized representatives have the authority to choose ODJFS-administered waiver service providers as outlined in paragraph (B) of this rule.

(D) If a consumer and/or authorized representative chooses to receive waiver services from an agency provider, the consumer and/or authorized representative shall comply with the requirements set forth in paragraphs (D)(1) to (D)(15) of this rule.

(1) Participate in the development of the all services plan and all plans of care.

(2) Decide whether anyone besides the case manager will participate in the face-to-face development of the all services plan and all plans of care.

(3) Authorize the CMA to exchange information for development of the all services plan with all of the consumer's service providers.

(4) Participate in the development and maintenance of service back-up plans that meet the needs of the consumer.

(5) Communicate to the service provider assigned and employed by the agency provider, and the agency provider management staff, personal preferences about the duties, tasks and procedures to be performed.

(6) Work with the CMA and the agency provider to identify and secure additional service provider orientation and training within the agency/caregiver scope of practice in order to meet the consumer's specific needs.

(7) Agree that the service provider assigned and employed by the agency provider must adhere to all relevant ODJFS-administered waiver program requirements, medicaid rules and regulations, and the agency provider's policies and procedures.

(8) Report to the case manager and the agency provider, in accordance with rule ~~5101:3-12-29~~ 5101:3-45-05 of the Administrative Code, incidents that may impact the health and welfare of the consumer.

(9) Communicate to the case manager any significant changes, as defined in rule 5101:3-45-01 of the Administrative Code, that may affect the provision of services, or result in a need for more or fewer hours of service.

(10) Provide verification that services have been furnished to the consumer, or approve provider timesheets only after services have been furnished. The consumer and/or authorized representative shall never approve blank timesheets, or timesheets that have been completed before services have been furnished.

(11) Participate in the recruitment, selection and dismissal of the agency provider and service provider assigned and employed by the agency provider.

(12) Notify the agency provider if the consumer is going to miss a scheduled visit.

(13) Notify the agency provider if the service provider assigned and employed by the agency provider misses a scheduled visit.

(14) Notify the case manager when any change in agency provider and/or service provider assigned and employed by the agency provider is necessary. Notification shall include the end date of the former agency provider and/or service provider, and the start date of the new provider.

(15) Participate in the monitoring of the performance of the agency provider, and the service provider assigned and employed by the agency provider.

(E) If a consumer and/or authorized representative chooses to receive waiver services from a non-agency provider, the consumer and/or authorized representative shall comply with the requirements set forth in paragraphs (E)(1) to (E)(~~18~~19) of this rule.

(1) Participate in the development of the all services plan and all plans of care.

(2) Decide whether anyone besides the case manager will participate in the face-to-face development of the all services plan and all plans of care.

(3) Authorize the CMA to exchange information for development of the all services plan with all of the consumer's service providers.

(4) Participate in the development and maintenance of service back-up plans that meet the needs of the consumer.

(5) Communicate to each non-agency provider personal preferences about the duties, tasks and procedures to be performed.

(6) Work with the CMA and non-agency provider to identify and secure additional orientation and training within the non-agency provider's scope of practice, in order to meet the consumer's specific needs.

(7) Work with the CMA and the non-agency provider to identify and secure continuing education within the non-agency provider's scope of practice. The consumer may participate in or conduct the continuing education.

~~(7)~~(8) Agree that the non-agency provider must adhere to all relevant ODJFS-administered waiver program requirements and medicaid rules and regulations.

~~(8)~~(9) Report to the case manager, in accordance with rule ~~5101:3-12-29~~ 5101:3-45-05of the Administrative Code, incidents that may impact the health and welfare of the consumer.

~~(9)~~(10) Communicate to the case manager any significant changes, as defined in rule 5101:3-45-01 of the Administrative Code, that may affect the provision of services, or result in a need for more or fewer hours of service.

~~(10)~~(11) Approve non-agency provider timesheets only after services have been furnished to the consumer. The consumer and/or authorized representative shall never approve blank timesheets, or timesheets that have been completed before services have been furnished to the consumer.

~~(11)~~(12) Participate in the recruitment, selection and dismissal of the non-agency provider.

~~(12)~~(13) Notify the non-agency provider if the consumer is going to miss a scheduled visit.

~~(13)~~(14) Notify the CMA if the non-agency provider misses a scheduled visit.

~~(14)~~(15) Notify the case manager when any change in non-agency provider is necessary. Notification shall include the end date of the former non-agency provider and the start date of the new provider.

~~(15)~~(16) Designate a location in the consumer's home in which the consumer, and the non-agency provider can safely store a copy of the consumer's clinical record in a manner that protects the confidentiality of this record, and for the purpose of contributing to the continuity of the consumer's care.

~~(16)~~(17) Participate in the monitoring of the performance of the non-agency provider.

~~(17)~~(18) Agree that each non-agency provider must complete ~~an annual~~ a structural review in accordance with rule ~~5101:3-12-30~~ 5101:3-45-06 of the Administrative Code.

~~(18)~~(19) Make the consumer's clinical record identified in paragraph (E)(15) of this rule available upon request by ODJFS or the CMA.

(F) If the consumer and/or authorized representative chooses to receive ODJFS-administered waiver services from a combination of agency and non-agency providers, the consumer and/or authorized representative must agree to participate in all activities set forth in paragraphs (D) and (E) of this rule.

(G) The CMA shall comply with all of the requirements set forth in paragraphs (G)(1) to (G)(8) of this rule.

(1) Assure the health and welfare of the consumer while acknowledging the consumer's right to make informed decisions and accept the resulting consequences that may impact the consumer's life.

(2) Upon the consumer's enrollment in an ODJFS-administered waiver, provide the consumer and/or authorized representative with the administrative rules, the consumer's rights and responsibilities, and other waiver-related information and materials, using communication mechanisms that are most effective for the consumer and/or authorized representative. The case manager shall review these materials with the consumer and/or authorized representative and assist him or her to understand his or her specific responsibilities.

(3) Work with the consumer and/or authorized representative to do the following:

(a) Select and direct approved waiver service providers;

(b) Develop the all services plan;

(c) Exchange information with all of the consumer's service providers for development of the all services plan;

(d) Develop and maintain service back-up plans that meet the needs of the consumer;

(e) Identify and secure additional provider orientation and training that is within the provider's scope of practice and meets the consumer's needs; and

(f) Upon request, identify and secure agency and/or non-agency providers when the consumer and/or authorized representative notifies the case manager that a change is necessary.

(4) Report to ODJFS, and when appropriate investigate, incidents that may impact the health and welfare of the consumer, in accordance with rule ~~5101:3-12-29~~ - 5101:3-45-05 of the Administrative Code.

(5) Address significant changes, as defined in rule 5101:3-45-01 of the Administrative Code, experienced by the consumer that may affect the provision of services or result in a need for more or fewer hours of service.

(6) Act as a facilitator to assist in resolving conflicts between the consumer and/or authorized representative, and the provider(s).

(7) Document, in writing, that the consumer and/or authorized representative:

(a) Understands the consumer's specific needs;

(b) Possesses the skills necessary to meet the requirements set forth in paragraph (D), (E) or (F) of this rule, as appropriate;

(c) Demonstrates an understanding of his or her responsibilities pursuant to paragraph (G)(2) of this rule; and

(d) Identifies the method by which the consumer and/or authorized representative will verify that services have been furnished as identified on the all services plan.

(8) Communicate with the consumer and/or authorized representative in a manner that protects the consumer's right to confidentiality.

(H) If the CMA determines that the consumer and/or authorized representative cannot meet the requirements set forth in paragraph (E) of this rule, and/or the health and welfare of the consumer receiving services from a non-agency provider cannot be assured, then the CMA may require the consumer receive services from only agency providers. The consumer will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

*** DRAFT – NOT FOR FILING ***

5101:3-45-10 **Conditions of participation for Ohio department of job and family services (ODJFS) administered waiver service providers.**

(A) ODJFS-administered waiver service providers shall:

(1) Maintain an active, valid medicaid provider agreement as set forth in rule 5101:3-1-17.3 of the Administrative Code.

(2) Comply with all provider requirements as set forth in Chapter 5101:3-45 of the Administrative Code, and Chapter(s) 5101:3-46, 5101:3-47 and/or 5101:3-50 of the Administrative Code, depending upon the waiver(s) for which the provider is furnishing services. Provider requirements include, but are not limited, to:

(a) Provider enrollment as set forth in rule 5101:3-45-04;

(b) Provider service specifications as set forth in rule(s) 5101:3-46-04, 5101:3-47-04 and/or 5101:3-50-04 of the Administrative Code, as applicable;

(c) Criminal record checks as set forth in rule 5101:3-45-07 or 5101:3-45-08 of the Administrative Code, as applicable;

(d) Consumer incident reporting as set forth in rule 5101:3-45-05 of the Administrative Code; and

(e) Provider monitoring and reviews as set forth in rule 5101:3-45-06 of the Administrative Code.

(3) Deliver services professionally, respectfully and legally.

(4) Comply, and maintain documentation of compliance, with the patient rights standards set forth in the medicare conditions of participation for home heath agencies as set forth in 42 C.F.R. 484 (as in effect on the effective date of this rule).

(5) Participate in all mandatory provider training sessions sponsored by ODJFS or its designee.

(6) Assure consumers receive ODJFS-administered waiver services in accordance with the consumer's all services plan.

(a) Medicare-certified home health agencies and otherwise-accredited agencies shall make every reasonable effort to replace staff when the provider's regularly scheduled staff cannot or do not meet their obligation to provide services to the consumer.

(b) At the direction of the consumer, non-agency providers shall assist the consumer upon initiation of services, as appropriate, in developing a backup plan in the event the regularly scheduled non-agency provider cannot or does not meet their obligation to provide services to the consumer.

(7) Upon request and within the timeframe prescribed in the request, provide information to ODJFS, its designee and the centers for medicare and medicaid services (CMS).

(8) Comply with all federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA) regulations as set forth in 45 C.F.R. parts 160, 162 and 164 (as in effect on the effective date of this rule), and the medicaid confidentiality regulations as set forth in 42 C.F.R. 421.300 through 306 (as in effect on the effective date of this rule); and Sections 5101.26 to 5101.28 of the Revised Code.

(9) Notify ODJFS and its designee, in writing, within thirty calendar days of changes in address, telephone number, email address and other contact information.

(10) Maintain and retain all required documentation including, but not limited to, documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider, and the consumer or 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 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.

(11) 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.

(12) Cooperate with ODJFS and its designee during all provider monitoring activities by being available to answer questions during reviews, and by assuring the availability and confidentiality of consumer information and other documents that may be requested as part of provider monitoring activities.

(13) Notify ODJFS or its designee within twenty-four hours and provide written documentation within five calendar days when the provider is aware of issues that may affect service delivery to the consumer. Issues may include, but are not limited to the following:

(a) The consumer consistently declines services.

(b) The consumer moves to another residential address.

(c) There are changes in the physical, mental and/or emotional status of the consumer.

(d) There are changes in environmental conditions affecting the consumer.

(e) The consumer's caregiver status has changed.

(f) The consumer no longer requires medically necessary services as defined in rule 5101:3-1-01 of the Administrative Code.

(g) The consumer has experienced a reportable incident as set forth in rule 5101:3-45-05 of the Administrative Code.

(h) A referral has been made to a protective service agency on the consumer's behalf, or an active case is pending.

(i) The consumer is behaving inappropriately toward the provider.

(j) The consumer is consistently noncompliant with physician orders, or is noncompliant with physician orders in a manner that may jeopardize the consumer's health and welfare.

(k) The consumer's requests consistently conflict with the approved all services plan.

(l) The consumer has been hospitalized or visited the emergency room.

(m) The consumer has been placed in an institutional setting.

(n) The consumer is experiencing other health and welfare issues.

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

(15) Submit written notification to the consumer and ODJFS or its designee at least thirty calendar days prior to the anticipated last date of service if the provider is terminating the provision of ODJFS-administered waiver services to the consumer. Exceptions to the thirty-day advance notification requirement are set forth in subparagraphs (A)(15)(a) to (A)(15)(c) of this rule, and are subject to verbal notification within twenty-four hours of the last date of service, and written notification within five calendar days of the last date of service.

(a) Thirty-day advance notification is not required when the consumer:

(i) Has been hospitalized for at least three days;

(ii) Has been placed in an institutional setting;

(iii) Has been incarcerated;

(iv) Has died;

(v) Is terminating the services of the provider; or

(vi) Is no longer eligible for medicaid.

(b) Thirty-day advance notification is not required when the provider is furnishing services in an environment that places the provider in imminent danger.

(c) Thirty-day advance notification may be waived for the provider by ODJFS or its designee on a case-by-case basis.

(B) ODJFS-administered waiver service providers may submit an e-mail address to ODJFS and/or its designee in order to receive electronic notification of any rule adoption, amendment or rescission, and any other communications from ODJFS or its designee that are not confidential pursuant to law.

(C) ODJFS-administered waiver service providers shall not:

(1) Submit a claim for waiver services rendered while the consumer is hospitalized, institutionalized or incarcerated. The only exception to this prohibition is when the consumer in institutionalized for the purpose of receiving out-of-home respite as set forth on the consumer's all services plan.

(2) Consume the consumer's food and/or drink without the consumer's offer and consent.

(3) Bring children, pets, friends, relatives, other consumers or anyone else to the consumer's place of residence.

(4) Take the consumer to the provider's place of residence.

(5) Use illegal drugs or chemical substances.

(6) Consume alcohol or take medications that may in any way impair the provider during the delivery of services to the consumer.

(7) Provide services to the consumer when the provider is medically, physically or emotionally unfit.

(8) Discuss religion or politics with the consumer and others in the care setting.

(9) Discuss personal issues with the consumer and others in the care setting.

(10) Accept, obtain or attempt to obtain money or anything of value, including gifts or tips from the consumer, authorized representative, household members and family members of the consumer.

(11) Borrow money, credit cards or other items from the consumer, authorized representative, household members and family members of the consumer.

(12) Be designated on a financial account or credit card held by the consumer, authorized representative, household members and family members of the consumer.

(13) Use the property of the consumer, authorized representative, household members and family members for personal gain.

(14) Lend or give the consumer, authorized representative, household members and family members money or other personal items.

(15) Engage with the consumer in sexual activity, or in conduct that may reasonably be interpreted as sexual in nature, regardless of whether or not the contact is consensual.

(16) Engage in behavior that causes or may cause physical, verbal, mental or emotional distress or abuse to the consumer.

(17) Engage in behavior that may reasonably be interpreted as inappropriate involvement in the consumer's personal relationships.

(18) Leave the home for a purpose unrelated to the provision of services without notifying the agency supervisor, the consumer's emergency contact person, identified caregiver and/or case manager.

(19) Use the consumer's motor vehicle, unless solely for the benefit of the consumer.

(20) Engage in activities that may distract from service delivery including, but not limited to:

(a) Watching television or playing computer or video games.

(b) Making or receiving personal communications.

(c) Engaging in non-care-related socialization with individuals other than the consumer.

(d) Providing care to individuals other than the consumer.

(e) Smoking without the consent of the consumer.

(f) Sleeping.

(21) Sell to, or purchase from, the consumer products or personal items unless the provider is a family member and the transaction occurs when the provider is not furnishing waiver services.

(22) Engage in behavior that takes advantage of or manipulates the consumer, the consumer's authorized representative or family, or the ODJFS-administered waiver program rules resulting in an advantage for personal gain.

(23) Use information about the consumer, authorized representative or the consumer's family for personal gain.

(D) ODJFS-administered waiver service providers shall not be designated to serve or make decisions for the consumer in any capacity involving a declaration for mental health treatment, durable power of attorney, financial power of attorney, or guardianship pursuant to court order, or representative payee as that term is described in paragraph (D)(3) of this rule, unless one or more of the following exceptions applies:

(1) A family member is appointed by the court pursuant to Section 2111.01 of the Revised Code as a legal guardian for the consumer.

(2) The consumer's designee pursuant to a declaration for mental health treatment, durable power of attorney or financial power of attorney is the consumer's parent or spouse.

(3) A parent or spouse is serving as the consumer's representative payee. For the purposes of this rule, "representative payee" means a parent or spouse who the consumer designates to receive and manage payments that would otherwise be made directly to the consumer.

(4) For non-family members, both of the following conditions apply:

(a) The provider was the consumer's paid medicaid provider prior to September 1, 2005; and

(b) The provider was appointed, and was already serving as, the consumer's designee pursuant to a declaration for mental health treatment, durable power of attorney, financial power of attorney or guardianship pursuant to court order prior to September 1, 2005.

(E) Agency providers shall pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements.

(F) 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 ODJFS-approved affidavit stating that they paid their applicable federal, state and local income and employment taxes.

(G) Failure to meet the requirements set forth in this rule may result in suspension of a provider's medicaid provider agreement in accordance with rule 5101:3-1-17.5 of the Administrative Code, or any of the actions set forth in rule 5101:3-45-09 of the Administrative Code including, but not limited to, termination of the medicaid provider agreement in accordance with rule 5101:3-1-17.6 of the Administrative Code. The provider shall be entitled to a hearing under Chapter 119. of the Revised Code in accordance with Chapter 5101:6-50 of the Administrative Code.

*** DRAFT – NOT FOR FILING ***

5101:3-46-04 **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 5101:3-46-06 of the Administrative Code.

(A) Waiver nursing services.

(1) "Waiver nursing services" are defined as services provided to Ohio home care waiver consumers that require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing waiver nursing services to consumers on the Ohio home care waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted there under, and shall possess a current, ~~and~~ valid and unrestricted license ~~in good standing~~ with the Ohio board of nursing.

(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 the 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 there under and to be performed by individuals 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 sole purpose of meeting the supervisory requirements as set forth in ~~paragraphs~~ paragraph (B)(6)(c) ~~and (B)(6)(d)~~ of this rule; ~~or~~

(d) Visits performed for the sole purpose of conducting an "OASIS" (outcome and assessment information set) assessment or any other assessment;

(e) Visits performed for the sole purpose of meeting the home care attendant service nurse consultation requirements set forth in rules 5101:3-46-04.1 and 5101:3-50-04.1 of the Administrative Code; or

~~(d)~~(f) Services performed in excess of the number of hours approved pursuant to, and specified on, the consumer's all services plan.

(4) 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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

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

~~(b)~~(d) Not be the consumer's legally responsible family member as that term is defined in ~~paragraph (EE) of~~ rule 5101:3-45-01 of the Administrative Code, unless the legally responsible family member is employed by a medicare-certified, or otherwise-accredited home health agency~~;~~.

~~(c)~~(e) Not be the foster caregiver of the consumer~~;~~.

~~(d)~~(f) Be identified as the provider ~~on~~ and have specified on, the consumer's all services plan that is prior-approved by ~~the designated case management agency (CMA)~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish waiver nursing services to the consumer~~;~~

~~(e)~~(g) Be identified as the provider on, and be performing nursing services pursuant to ~~signed and dated written orders from the treating physician~~ the consumer's plan of care, as that term is defined in rule 5101:3-45-01 of the Administrative Code~~; and.~~. The plan of care must be signed and dated by the consumer's treating physician.

~~(f)~~(h) Be providing the service for one individual, or for up to three individuals in a group setting, during a face-to-face nursing visit.

(5) 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

(b) Conduct a face-to-face visit with the consumer and the directing RN prior to initiating services and ~~no less than~~ at least every one hundred twenty days for the purpose of evaluating the provision of waiver nursing services, the consumer'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.

(6) All waiver nursing service providers must maintain a clinical record for each consumer 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 consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs (A)(6)(a) to (A)(6)(~~k~~l) of this rule.

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer'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 consumer'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 the face-to-face visits between the LPN and the directing RN, and documenting the face-to-face visits between the LPN, the consumer 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 ~~the~~ any advance directives including, but not limited to, "do not resuscitate" (DNR) order or medical power of attorney, if ~~one exists~~ they exist.

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

~~(i)~~(j) ~~Clinical notes, signed and dated by the nurse, documenting the services performed during, and outcomes resulting from, each nursing visit.~~ Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider, and consumer or authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the ~~use of technology-based systems in collecting and maintaining the documentation required by this paragraph~~ collection and maintenance of documentation through technology-based systems. The consumer'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.

~~(j)~~(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.

~~(k)~~(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 consumer, or when the consumer 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 consumer with activities of daily living (ADL) and instrumental activities of daily living (IADL) ~~impairments~~ needs. If the 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. ~~Personal care aide service providers may elect not to furnish one or more of the listed services.~~ If the provider ~~so elects~~ cannot perform IADLs, the provider must notify ~~the designated CMA~~, ODJFS or its designee, in writing, of the ~~services the provider elects not to furnish~~. service limitations prior to inclusion on the 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 consumer; and

(e) Accompanying or transporting the consumer to Ohio home care waiver services, medical appointments, other community services, or running errands on behalf of the consumer.

(2) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to, and specified on, the consumer's all services plan.

(3) Personal care aides shall not administer prescribed or over-the-counter medications to the consumer, but may, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph ~~(B)~~ (C) of rule ~~4723-13-04~~ 4723-13-02 of the Administrative Code, help the consumer self-administer medications by:

(a) Reminding the consumer when to take the medication, and observing to ensure the consumer follows the directions on the container;

(b) Assisting the consumer by taking the medication in its container from where it is stored and handing the container to the consumer;

(c) Opening the container for a consumer who is physically unable to open the container;

(d) Assisting a consumer 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 a consumer 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 consumer.

(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 individuals providing personal care aide services must meet the following:

(a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

~~(a)~~(c) Be at least eighteen years of age~~;~~.

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

~~(c)~~(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~~;~~.

~~(d)~~(f) Not be the consumer's legally responsible family member as that term is defined in ~~paragraph (EE) of~~ rule 5101:3-45-01 of the Administrative Code~~;~~.

~~(e)~~(g) Not be the foster caregiver of the consumer~~;~~.

~~(f)~~(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~~; and~~.

~~(g)~~(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 ~~home health~~ agencies must assure that personal care aides meet the following requirements:

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

(i) Obtain a certificate of completion of either ~~the nurse aide~~ 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 ~~47~~ 42 C.F.R. 484 (~~2005~~as in effect on the effective date of this rule), 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 ~~eight~~ twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately ~~after the personal care aide's first anniversary of employment with the agency~~, 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 consumer home visit explaining the expected activities of the personal care aide, and identifying the consumer's personal care aide services.

(ii) Conduct a face-to-face consumer home visit at least every sixty days ~~after the initial visit~~ while the personal care aide is present and providing care to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery~~,~~ and personal care aide performance. The visit must be documented in the consumer's record.

~~(iii) Conduct a face-to-face consumer home visit at least every one hundred twenty days while the personal care aide is present and providing care. The visit must be documented in the consumer's record.~~

~~(iv)~~(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 consumer.

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

(a) Prior to commencing service delivery personal care aides must have:

(i) Obtained a certificate of completion within the last twenty-four months for either ~~the nurse aide~~ 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 ~~47~~ 42 C.F.R. 484 (~~2005~~as in effect on the effective date of this rule); 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 ~~infection control~~ 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 ~~eight~~ 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, consumer 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.

(c) Comply with the consumer's or the consumer's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the consumer or the case manager.

(d) Comply with ODJFS monitoring requirements in accordance with rule ~~5101:3-12-30~~ 5101:3-45-06 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 consumer.

(8) All personal care aide providers must maintain a clinical record for each consumer 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 personal care aides must maintain the clinical records at their place of business, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs (B)(8)(a) to (B)(8)(i) of this rule.

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

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

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

(g) Documentation ~~that clearly shows the date of service delivery, the personal care aide service tasks performed or not performed, the arrival and departure times, and the signatures of the personal care aide and consumer or authorized representative upon completion of service delivery.~~ of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the ~~use of~~ collection and maintenance of documentation through technology-based systems ~~in collecting and maintaining the documentation required by this paragraph~~. The consumer'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.

(h) Progress notes signed and dated by the personal care aide, documenting all communications with the CM, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.

(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 consumer, or when the consumer no longer needs personal care aide services. The summary should include documentation regarding progress made toward achievement of goals as specified on the consumer'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 consumers age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that ~~is used solely for the provision of ADHCS~~ shall not be used for other purposes during the provision of ADHCS.

(a) The services the adult day health center must ~~make available~~ 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) ~~No~~ At least one, but no more than two, meals per day that meet the consumer'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 5101:3-12-01 of the Administrative Code;

(ii) Transportation of the consumer to and from ADHCS.

(c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to a consumer in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided to a consumer on 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 consumer'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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider, and specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish adult day health center services to the consumer~~; and~~.

~~(b)~~(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 42 C.F.R. 80 (~~1964~~as in effect on the effective date of this rule).

(b) Provide for replacement coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its ~~designated CMA~~ designee - verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of ~~eight~~ - twelve 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 ~~limited~~ 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~~ set forth in paragraph (B)(1) of this rule.

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

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

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

(e) A copy of ~~the~~ any advance directive including, but not limited to, ~~"do not resuscitate" (~~DNR~~)~~ order or medical power of attorney, if ~~one exists~~ they exist.

(f) Documentation of ~~drug~~ 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 consumer's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by the 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 consumer, or when the consumer 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), ~~and~~ (A)(6)(j) and (A)(6)(k) of this rule when the consumer 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 a consumer 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 a consumer at his or her home. A consumer may be authorized to receive up to two home delivered meals per day.

(2) Home delivered meals:

(a) Shall be planned and approved in writing by a dietitian, taking into consideration the consumer's medical restrictions, religious, cultural and ethnic background and dietary preferences.

(b) Shall be prepared by a provider who is in compliance with the food preparation and food safety requirements set forth in Chapters 918, 3715 and 3717 of the Revised Code, as appropriate, and 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.

(c) Shall be individually packaged.

(d) Shall include at least two shelf-stable meals that serve as a back-up in case an emergency prevents planned meal delivery. Back-up meals shall be furnished at no cost to the department, its designee, or the consumer or authorized representative.

(e) 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 consumer's diet. A therapeutic diet must be prescribed by a licensed physician or dietitian. Authorization must be documented in the consumer's clinical record every sixty days.

(3) Home delivered meals shall not:

(a) Include services or activities performed in excess of what is approved on the consumer'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 consumer 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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of home delivered meal services in accordance with rule 5101:3-46-06 of the Administrative Code.

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

(d) Possess a current food service operation license, and maintain copies of all inspection reports from the Ohio department of agriculture, as required.

(e) Possess all other applicable licenses or certificates, and maintain copies of all related reports, as required.

(f) Assure that all meals are prepared and delivered as identified on the consumer's all services plan.

(g) Submit claims that do not exceed two meals per day per consumer.

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

(a) Meet current recommended dietary allowances (RDA) and dietary reference intakes (DRI) established by the food and nutrition board of the institute of medicine of the national academy of sciences.

(b) Comply with one-third of the current dietary guidelines for Americans as published by the United States department of health and human services and the United States 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 consumer's all services plan.

(a) All food items must be labeled with an expiration date.

(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 custom-built, temperature-controlled food delivery vehicle, the provider must maintain verification of testing meal temperatures at least monthly. When using other food delivery vehicles, the provider must maintain verification of testing meal temperatures at least weekly.

(e) The provider must establish a routine delivery time with the consumer and notify the consumer 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 ensure that the consumer or authorized representative clearly understands how to safely reheat each meal.

(h) Verification that shelf-stable back-up meals are in the home and are replaced prior to their expiration date or upon consumption.

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

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

(i) Receive training and orientation on the following:

(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 relevant continuing education each year on the topics set forth in paragraph (D)(7)(a) of this rule.

(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 consumer served that contains a copy of the initial and all subsequent all services plans, all dietary prescriptions and instructions prepared by the physician, dietitian and any other clinicians, and any additional information supporting meal delivery as specified on the all services plan.

(b) Documentation that each meal meets the RDA and DRI guidelines required by paragraphs (D)(5)(a) and (D)(5)(b) of this rule.

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

(d) Documentation from the provider that the consumer or authorized representative clearly understands how to safely reheat each meal.

(e) Documentation verifying that shelf-stable back-up meals are in the home and are replaced prior to their expiration or upon consumption.

(f) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery, time of delivery of all meals, number of meals delivered at each visit, signature or initials of the person delivering the meal and signature of the consumer or authorized representative receiving the meal(s). Nothing shall prohibit the collection or maintenance of documentation through technology-based systems. The consumer'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.

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

(h) Documentation of vehicle owner's collision and liability insurance.

(i) Documentation that the provider has established a routine delivery time with the consumer.

(j) All local health department inspection reports, and resulting plans of correction.

(k) All Ohio department of agriculture inspection reports and findings, and resulting plans of correction.

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

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

(a) Home delivered meal service providers cited for critical items during their local health department inspections shall notify the department or its designee within two business days of the citation. The provider shall immediately send to the department or its designee a copy of the inspection report, and all plans of correction and follow-up reports.

(b) Home delivered meal service providers inspected by the Ohio department of agriculture division of food safety and placed on priority or notice status shall notify the department or its designee within two business days of the issuance of the findings. The provider shall, within five business days, send to the department or its designee, a copy of the findings report and any notices issued by the Ohio department of agriculture, and all 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 shall notify the department or its designee within two business days of an action taken as defined in 9 C.F.R. 500.3 and/or 9 C.F.R. 500.4 (as in effect on the effective date of this rule). The provider shall, within five business days, send to the department or its designee, a copy of the action issued by the Ohio department of agriculture, and all resulting plans of correction and follow-up reports.

(d) The department may immediately suspend and terminate a provider's authorization to furnish home delivered meal services pursuant to Section 5111.06 of the Revised Code and rule 5101:3-1-17.6 of the Administrative Code if the department or its designee receives credible information that the provider poses a significant threat to the health and welfare of one or more consumers due to noncompliance with one or more of the requirements set forth in this rule.

~~(D) Home delivered meal services.~~

~~(1) "Home-delivered meal services" are defined as the provision of individual meals to consumers. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician, taking into consideration the consumer's cultural and ethnic background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.~~

~~(2) Home-delivered meals do not include services performed in excess of what is approved pursuant to the all services plan.~~

~~(3) In order to submit a claim for reimbursement, all providers of home-delivered meal services must:~~

~~(a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;~~

~~(b) Possess a valid food vendor's license;~~

~~(c) Assure that all meals are prepared and delivered as identified on the all services plan; and~~

~~(d) Only submit a claim for up to two meals per day per consumer.~~

~~(4) Home-delivered meal service providers must maintain the documentation identified in paragraphs (D)(4)(a) to (D)(4)(d) of this rule.~~

~~(a) Daily route logs, signed and dated by the home-delivered meal service provider, with consumer names appearing on the log in order of delivery with the time of first and last meal delivered, number of meals at each visit, initials of person delivering the meal and initials of the consumer or authorized representative receiving the meal(s).~~

~~(b) A record for each consumer served that contains a copy of the initial and all subsequent all service plans, all dietary instructions prepared by the dietician and any additional information supporting meal delivery as specified on the all services plan.~~

~~(c) All appropriate food vendor's licenses.~~

~~(d) Evidence of a time/temperature monitoring system for food preparation, handling and delivery.~~

~~(5) Upon request, home-delivered meal service providers shall make available to ODJFS or its designated CMA a copy of any local health department inspection reports.~~

~~(6) Home-delivered meal service providers cited for critical items during their local health department inspection shall make available a copy of that inspection report and the follow-up report to ODJFS or its designated CMA within five working days of receipt from the inspecting agent.~~

~~(7) Home-delivered meal service providers cited by the Ohio department of agriculture shall make available to ODJFS or its designated CMA a copy of the findings and corresponding plans of correction within five working days of receipt from the regulatory agent.~~

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer 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 consumer 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~~ -month calendar year ~~period~~ per consumer. ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer'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 ~~in an evaluation completed~~ by an occupational therapist or physical therapist as licensed pursuant to sections ~~4755.07~~ 4755.08 and 4755.44 of the Revised Code, during an in-person evaluation of the site to be modified, and with the consumer 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 consumer (i.e., carpeting, roof repair, central air conditioning, etc.)~~;~~.

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

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

(d) The same type of home modification for the same consumer during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the consumer'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 ~~the designated CMA~~ ODJFS 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 ~~will~~ 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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the home modification services that the provider is authorized to furnish to the consumer~~;~~.

~~(b)~~(d) ~~Assure~~ 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~~;~~.

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

~~(d)~~(f) ~~Assure~~ Provide documentation that the home modification ~~met~~ meets all applicable state and local building codes ~~and complies with the Americans with Disabilities Act (ADA)~~;

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

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

~~(f)~~(i) Obtain a final written approval from the consumer and ~~the designated CMA~~ ODJFS or its designee after completion of the home modification service.

(5) Selection of home modification service providers.

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

(b) ~~The designated CMA~~ At a minimum, ODJFS or its designee shall send the home modification specifications to every known home modification service provider in the consumer's ~~region~~ county of residence and all contiguous counties, and shall invite the submission of competitive bids. ~~The following must be submitted with all 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 5101:3-45 and 5101:3-46 of the Administrative Code.

(c) ~~The designated CMA~~ ODJFS 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 transportation services.~~

~~(1) "Supplemental transportation services" are transportation services not otherwise covered by the Ohio medicaid program that enable a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include assistance in transferring the consumer 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 the all services plan.~~

~~(3) In order to submit a claim for supplemental transportation services, the provider must be identified as the provider on the consumer's all services plan that is prior approved by~~ the designated CMA~~.~~

~~(4) Agency supplemental transportation service providers must:~~

~~(a) Maintain a current list of drivers;~~

~~(b) Assure 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) Assure that drivers are not the consumers' legally responsible family members as that term is defined in paragraph (EE) of rule 5101:3-45-01 of the Administrative Code; and~~

~~(g) Assure that drivers are not the consumers' 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) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule 5101:3-45-01 of the Administrative Code; and~~

~~(f) Not be the consumer's foster caregiver.~~

~~(6) All supplemental transportation service providers must maintain documentation that includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip and the signature of the consumer receiving supplemental transportation services, or his or her authorized representative.~~

~~(G)~~(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 consumer, ~~or the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule 5101:3-45-01 of the Administrative Code,~~ or a family member, or someone who resides in the same household as the consumer, that are not otherwise available through any other funding source and that are suitable to enable the consumer 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 ODJFS or its

designee. ~~The designated CMA~~ ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.

(a) Reimbursement for medical equipment, ~~and~~ supplies and vehicle modifications shall not exceed a combined total of ten thousand dollars within a ~~twelve-month period~~ calendar year per consumer. ~~The designated CMA shall not approve the same type of medical equipment, supplies and devices for the same consumer for a one-year period unless there is a documented need for ongoing medical supplies or a documented change in the consumer's medical and/or physical condition requiring the replacement.~~

(b) ODJFS or its designee shall not approve the same type of medical equipment, supplies and devices for the same consumer 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 consumer's medical and/or physical condition requiring the replacement.

~~(b)~~(c) ~~Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA~~ - ODJFS or its designee shall not approve the same type of vehicle modification for the same consumer ~~for a~~ within the same three-year period, unless there is a documented change in the consumer'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 consumer'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 consumer. 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.

~~(2)~~(b) ~~Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, portable ramps, 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 consumer.~~ Prior to the authorization of a vehicle modification, the consumer and, if applicable, any other person(s) who will operate the vehicle must provide ~~the designated CMA~~ ODJFS or its designee with documentation of:

~~(a)~~(i) ~~Evidence of a~~ 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 consumer and/or other person(s) operating the vehicle;

(ii) Proof of ownership of the vehicle to be modified;

~~(b) Evidence of the successful completion of driver training from a qualified driver rehabilitation specialist or a written statement from a driver's rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other persons operating the vehicle;~~

~~(c)~~(iii) ~~Evidence of the vehicle~~ Vehicle owner's collision and liability insurance for the vehicle being modified; and

~~(d)~~(iv) A written statement from a certified mechanic stating the vehicle is in good operating condition.

~~(3)~~(c) ~~Supplemental adaptive and assistive device services~~ Vehicle modifications do not include:

~~(a) Items considered by the federal food and drug administration as experimental or investigational;~~

~~(b) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;~~

~~(c)~~(i) Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (F)(2)(a) of this rule;

~~(d)~~(ii) Routine care and maintenance of vehicle modifications and devices;

~~(e)~~(iii) Permanent modification of leased vehicles;

~~(f)~~(iv) Vehicle inspection costs;

~~(g)~~(v) Vehicle insurance costs; ~~and~~

(vi) New vehicle modifications or repair of previously-approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and

~~(h)~~(vii) Services performed in excess of what is approved pursuant to, and specified on, the consumer's all services plan.

~~(4)~~(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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the consumer;

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

~~(c)~~(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.

~~(5)~~(4) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs ~~(G)(5)(a) to (G)(5)(d)~~ (F)(4)(a) to (F)(4)(d) of this rule.

(a) Consumer 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.

(b) Name of consumer'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.

~~(H)~~(G) Out-of-home respite services.

(1) "Out-of-home respite services" are services delivered to a consumer 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 consumer's dietary requirements.

(b) All services set forth in paragraph (~~H~~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 consumer'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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

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

~~(b)~~(d) Be either:

(i) An intermediate care facility for the mentally retarded and developmentally disabled (ICF-MR) licensed and certified in accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code; or

(ii) A nursing facility (NF) licensed and certified in accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code; or

(iii) Another ~~institutional~~ licensed setting approved by ~~the designated CMA~~ ODJFS or its designee.

~~(c)~~(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 42 C.F.R. 80 (~~1964~~as in effect on the effective date of this rule).

(b) Provide for coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its ~~designated CMA~~ 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 consumer served in a manner that protects the confidentiality of these records. -

At a minimum, the ~~The~~ clinical record must contain the information listed in paragraphs (~~H~~G)(5)(a) to (~~H~~G)(5)(i) of this rule.

(a) Consumer's 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

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

(f) Documentation of ~~drug~~ 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 consumer, or when the consumer 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) ~~and~~, (A)(6)(j) and (A)(6)(k) of this rule when the consumer is provided waiver nursing.

(H) Emergency response services.

(1) "Emergency response services (ERS)" are emergency intervention services comprised of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the consumer 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 activation devices from which the consumer can choose in accordance with the consumer's specific needs. 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 consumer is hearing impaired, or

(iii) Audible indication of an alarm that may be appropriate if the consumer 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 consumers under the age of eighteen.

(c) Remote monitoring services.

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

(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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

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

(5) ERS provider requirements.

(a) Providers shall assure that all consumers 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 ERS consumer with an initial face-to-face demonstration and training on how to use their ERS equipment. Further education may be provided to the consumer, caregiver, designated responders, and ODJFS or its designee at any time upon request.

(c) Prior to, or during the delivery of ERS equipment, the provider shall work with the consumer and/or the consumer's authorized representative, and the consumer's 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 no less than every six months.

(i) The written response plan shall include a summary of the consumer'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 consumer's designated responder. For the purposes of this rule, "designated responder" means an individual or individuals who the consumer and/or the consumer's 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 and ongoing training to all designated responders prior to activation of the consumer's ERS equipment. At a minimum, the training shall include:

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

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

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

(a) If the consumer 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 consumer 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, then emergency service personnel shall be designated as the responder in the plan.

(iv) In the event a consumer sends an alarm signal but a designated responder cannot be reached, the provider shall contact emergency service personnel.

(d) Providers shall assure that emergency response centers:

(i) Employ and train staff to receive and respond to alarm signals from consumers twenty-four hours per day, three hundred and 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 ODJFS or its designee of all emergencies involving a consumer within twenty-four hours.

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

(vii) Replace malfunctioning ERS equipment within twenty-four hours of notification, and at no additional cost to the consumer, or ODJFS or its designee.

(viii) Operate all ERS lines toll-free.

(6) At a minimum, providers of ERS must maintain the following documentation:

(a) A log containing the names and contact information of each consumer, and their authorized representative.

(b) A copy of each consumer's approved 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 5101:3-1-17.2 of the Administrative Code.

(d) Documentation of all consumer, 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 consumer's or authorized representative's signature verifying delivery and installation. The consumer'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 consumer's ERS equipment, including date, time and results of the test.

(g) A record of each service-related consumer contact 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 names of each person having contact with the consumer.

(h) A copy of the consumer'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 a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include, but are not limited to assistance in transferring the consumer 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 consumer'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 5101:3-45 and 5101:3-46 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

(c) Be identified as the provider, and have specified on, the consumer's all services plan that is prior-approved by ODJFS or its designee, the amount of supplemental transportation services the provider is authorized to furnish to the consumer.

(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 consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.

(h) Assure that drivers are not the consumer'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 consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.

(g) Not be the consumer's foster caregiver.

(6) All supplemental transportation service providers must maintain documentation that, at a minimum, includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip, and the signature of the consumer receiving supplemental transportation services, or the consumer's authorized representative. The consumer'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.

~~(I) Emergency response services.~~

~~(1) "Emergency response services (ERS)" are in-home, twenty-four-hour communication connection systems that enable a consumer at high risk of institutionalization to secure immediate assistance during a medical, physical, emotional, or environmental emergency. Consumers who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision are considered to be high risk for the purposes of this service.~~

~~(2) ERS do not include:~~

~~(a) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen; and~~

~~(b) Services performed in excess of what is approved pursuant to the all services plan.~~

~~(3) In order to submit a claim for ERS, all providers must be identified as the provider on the consumer's all services plan that is prior approved by~~ the designated CMA~~.~~

~~(4) Providers of ERS must:~~

~~(a) Permit consumers to select from a variety of remote activation devices;~~

~~(b) Assure that consumers have systems that meet their specific needs;~~

~~(c) Assure that emergency response systems meet all applicable quality assurance/quality control industry standards;~~

~~(d) Conduct monthly testing of emergency response systems to assure proper operation;~~

~~(e) Provide consumers, their authorized representatives, and caregivers with initial and ongoing training and assistance regarding the use of the emergency response system;~~

~~(f) Assure that the installation includes seize line circuitry guaranteeing that the emergency response system has priority over the telephone when the system is activated;~~

~~(g) Operate an emergency response center that is staffed twenty-four hours a day, three hundred sixty-five days a year to receive and respond to emergency signals;~~

~~(h) Assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;~~

~~(i) Assure that emergency response center staff respond to alarm messages within sixty seconds of receipt; and~~

~~(j) Furnish a replacement emergency response system or an activation device to the consumer within twenty-four hours of notification of a malfunction.~~

~~(5) Providers of ERS must maintain the following documentation:~~

~~(a) A log containing the names and contact information of each consumer and their authorized representatives' names and contact information;~~

~~(b) A written record of the date of delivery and installation of the emergency response system, with the consumer's or authorized representative's signature verifying delivery and installation;~~

~~(c) A record of the monthly test conducted on each consumer's emergency response system, including the date, time and results of the test; and~~

~~(d) A record documenting the date and time a consumer's emergency response system is activated and a summary of the incident and the action taken by the provider.~~

*** DRAFT – NOT FOR FILING ***

5101:3-47-04 **Transitions ~~MR/DD~~ DD waiver: definitions of the covered services and provider requirements and specifications.**

This rule sets forth the definitions of the services covered by the transitions ~~MR/DD~~ DD waiver. This rule also sets forth the provider requirements and specifications for the delivery of transitions ~~MR/DD~~ DD waiver services. The services are reimbursed in accordance with rule 5101:3-47-06 of the Administrative Code.

(A) Waiver nursing services.

(1) "Waiver nursing services" are defined as services provided to transitions ~~MR/DD~~ DD waiver consumers that require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing waiver nursing to consumers on the transitions ~~MR/DD~~ DD waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted there under, and they shall possess a current, ~~and~~ valid and unrestricted license ~~in good standing~~ with the Ohio board of nursing.

(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 the 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 to be adopted there under, and to be performed by individuals 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 sole purpose of meeting the supervisory requirements as set forth in ~~paragraphs~~ paragraph (B)(6)(c) ~~and (B)(6)(d)~~ of this rule; ~~and~~

(d) Visits performed for the sole purpose of conducting an "OASIS" (outcome and assessment information set) assessment or any other assessment;

(e) Visits performed for the sole purpose of meeting the home care attendant service nurse consultation requirements set forth in rules 5101:3-46-04.1 and 5101:3-50-04.1 of the Administrative Code; or

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

(4) 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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

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

~~(b)~~(d) Not be the consumer's legally responsible family member as that term is defined in ~~paragraph (R) of~~ rule 5101:3-45-01 of the Administrative Code, unless the family member is employed by a medicare-certified, or otherwise-accredited home health agency~~;~~.

~~(c)~~(e) Not be the foster caregiver of the consumer~~;~~.

~~(d)~~(f) Be identified as the provider ~~on~~ and have specified on, the consumer's all services plan that is prior-approved by ~~the designated case management agency (CMA)~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish waiver nursing services to the consumer~~;~~.

~~(e)~~(g) Be identified as the provider on, and be performing nursing services pursuant to ~~signed and dated written orders from the treating physician; and~~ the consumer's plan of care, as that term is defined in rule 5101:3-45-01 of the Administrative Code. The plan of care must be signed and dated by the consumer's treating physician.

~~(f)~~(h) Be providing the service for one individual, or for up to three individuals in a group setting, during a face-to-face nursing visit.

(5) 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

(b) Conduct a face-to-face visit with the consumer and the directing RN ~~no less than~~ prior to initiating services and at least every one hundred twenty days

for the purpose of evaluating the provision of waiver nursing services, the consumer'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.

(6) All waiver nursing service providers must maintain a clinical record for each consumer 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 consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs (A)(6)(a) to (A)(6)(~~k~~l) of this rule.

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer'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 consumer'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 the face-to-face visit between the LPN and the directing RN, and documenting the face-to-face visits between the LPN, the consumer 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 ~~the~~ any advance directives including, but not limited to, "do not resuscitate" (DNR) order or medical power of attorney, if ~~one exists~~ they exist.

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

~~(i)~~(j) ~~Clinical notes, signed and dated by the nurse, documenting the services performed during, and outcomes resulting from, each nursing visit. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.~~ Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or 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 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.

~~(j)~~(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.

~~(k)~~(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 consumer, or when the consumer 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 transitions ~~MR/DD~~ DD waiver's all services plan that assist the consumer with activities of daily living (ADL) and instrumental activities of daily living (IADL) ~~impairments~~ needs. If the 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 consists of services listed in paragraphs (B)(1)(a) to (B)(1)(e) of this rule. ~~Personal care aide service providers may elect not to furnish one or more of the listed services.~~ If the provider ~~so elects,~~ cannot perform IADLs, the provider must notify ~~the designated CMA,~~ ODJFS or its designee, in writing, of the ~~services the provider elects not to furnish~~ service limitations prior to inclusion on the 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 consumer; and

(e) Accompanying or transporting the consumer to transitions ~~MR/DD~~ DD - waiver services, medical appointments, other community services, or running errands on behalf of the consumer.

(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 consumer, but may, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph (~~B~~C) of rule ~~4723-13-04~~ 4723-13-02 of the Administrative Code, help the consumer self-administer medications by:

(a) Reminding the consumer when to take the medication, and observing to ensure the consumer follows the directions on the container;

(b) Assisting the consumer by taking the medication in its container from where it is stored and handing the container to the consumer;

(c) Opening the container for a consumer who is physically unable to open the container;

(d) Assisting a consumer 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 a consumer 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 consumer.

(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 individuals providing personal care aide services must meet the following:

(a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

~~(a)~~(c) Be at least eighteen years of age~~;~~.

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

~~(c)~~(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~~;~~.

~~(d)~~(f) Not be the consumer's legally responsible family member as that term family is defined in ~~paragraph (R) of~~ rule 5101:3-45-01 of the Administrative Code~~, unless the family member is employed by a medicare-certified or otherwise-accredited home health agency, and the consumer is the provider's adult child;~~.

~~(e)~~(g) Not be the foster caregiver of the consumer~~;~~.

~~(f)~~(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~~; and~~.

~~(g)~~(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 ~~home health~~ agencies must assure that personal care aides meet the following requirements:

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

(i) Obtain a certificate of completion of either ~~the nurse aide~~ 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 ~~47~~ 42 C.F.R. 484 (~~2005~~ as in effect on the effective date of this rule), 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 ~~eight~~ twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately ~~after the personal care aide's first anniversary of employment with the agency~~, 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 consumer home visit explaining the expected activities of the personal care aide, and identifying the consumer's personal care aide services.

(ii) Conduct a face-to-face consumer home visit at least every sixty days ~~after the initial visit~~ while the personal care aide is present and providing care to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery~~,~~ and personal care aide performance. The visit must be documented in the consumer's record.

~~(iii) Conduct a face-to-face consumer home visit at least every one hundred twenty days while the personal care aide is present and providing care. The visit must be documented in the consumer's record.~~

~~(iv)~~(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 transitions ~~MR/DD~~ DD waiver.

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

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

(a) Prior to commencing service delivery personal care aides must have:

(i) Obtained a certificate of completion within the last twenty-four months for either ~~the nurse aide~~ 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 ~~47~~ 42 C.F.R. 484 (~~2005~~ as in effect on the effective date of this rule); 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 ~~infection control~~ 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 ~~eight~~ 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 consumer health and safety, 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 consumer's or the consumer's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the consumer or the case manager.

(d) Comply with ODJFS monitoring requirements in accordance with rule ~~5101:3-12-30~~ 5101:3-45-06 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 transitions ~~MR/DD~~ DD waiver.

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

(8) All personal care aide providers must maintain a clinical record for each consumer 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 personal care aides must maintain the clinical records at their place of business in a manner that protects the confidentiality of these records, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. ~~The~~ At a minimum, the clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

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

(f) A copy of ~~the "do-not-resuscitate" (DNR)~~ any advance directives including, but not limited to, DNR order~~,~~ or medical power of attorney, ~~if one exists~~ if they exist.

(g) ~~Documentation that clearly shows the date of service delivery, the personal care aide service tasks performed or not performed, the arrival and departure times, and the signatures of the personal care aide and consumer or authorized representative upon completion of service delivery. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.~~ Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or 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 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 CM, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.

(i) A discharge summary, signed and dated by the departing non-agency personal care aide or RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the consumer, or when the consumer no longer needs personal care aide services. The summary should include documentation regarding progress made toward achievement of goals as specified on the consumer'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 consumers age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that ~~is used solely for the provision of ADHCS~~ shall not be used for other purposes during the provision of ADHCS.

(a) The services the adult day health center must ~~make available~~ 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) ~~No~~ At least one, but no more than two meals per day that meet the consumer'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 5101:3-12-01 of the Administrative Code;

(ii) Transportation of the consumer to and from ADHCS.

(c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to a consumer in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided to a consumer on 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 consumer'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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider on the consumer's all services plan that is prior-approved by ~~the designated CMA; and~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish ADHCS to the consumer.

~~(b)~~(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 42 C.F.R. 80 (~~1964~~ as in effect on the effective date of this rule).

(b) Provide for replacement coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its ~~designated CMA~~ designee - verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of ~~eight~~ - twelve 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 ~~limited~~ 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~~ set forth in paragraph (B)(1) of this rule.

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

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

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

(e) A copy of ~~the "do-not-resuscitate" (DNR) order, if one exists~~ any advance directive including, but not limited to, DNR order or medical power of attorney, if they exist.

(f) Documentation of ~~drug~~ 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 consumer's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by the 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 consumer, or when the consumer 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), ~~and~~ (A)(6)(j) and (A)(6)(k) of this rule when the consumer is provided waiver nursing and/or skilled therapy services.

(D) Home delivered meals services.

(1) "Home delivered meal service" is defined as the provision of meals to a consumer 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 a consumer at his or her home. A consumer may be authorized to receive up to two home delivered meals per day.

(2) Home delivered meals:

(a) Shall be planned and approved, in writing, by a dietitian, taking into consideration the consumer's medical restrictions, religious, cultural and ethnic background and dietary preferences.

(b) Shall be prepared by a provider who is in compliance with the food preparation and food safety requirements set forth in Chapters 918, 3715 and 3717 of the Revised Code, as appropriate, and 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.

(c) Shall be individually packaged.

(d) Shall include at least two shelf-stable meals that serve as back-up in case an emergency prevents planned meal delivery. Back-up meals shall be furnished at no cost to the department, its designee, or the consumer or authorized representative.

(e) May include a therapeutic diet that requires a daily amount or distribution of one or more specified nutrients in order to treat a disease or clinical condition, or eliminate, decrease or increase certain substances in the consumer's diet. Authorization must be documented in the consumer's clinical record every sixty days.

(3) Home delivered meals shall not:

(a) Include services or activities performed in excess of what is approved on the consumer'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 consumer 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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of home delivered meal services in accordance with rule 5101:3-47-06 of the Administrative Code.

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

(d) Possess a current food service operation license and maintain copies of all inspection reports from the Ohio department of agriculture, as required.

(e) Possess all other applicable licenses or certificates, and maintain copies of all related reports, as required.

(f) Assure that all meals are prepared and delivered as identified on the consumer's all services plan.

(g) Submit claims that do not exceed two meals per day per consumer.

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

(a) Meet current recommended dietary allowances (RDA) and dietary reference intakes (RDI) established by the food and nutrition board of the institute of medicine of the national academy of sciences.

(b) Comply with one-third of the current dietary guidelines for Americans as published by the United States department of health and human services and the United States 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 consumer's all services plan.

(a) All food items must be labeled with an expiration date.

(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 custom-built, temperature-controlled food delivery vehicle, the provider must maintain verification of testing meal temperatures at least monthly. When using other food delivery vehicles, the provider must maintain verification of testing meal temperatures at least weekly.

(e) The provider must establish a routine delivery time with the consumer and notify the consumer 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 ensure that the consumer or authorized representative clearly understands how to safely reheat each meal.

(h) Verification that shelf-stable back-up meals are in the home and are replaced prior to their expiration date or upon consumption.

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

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

(i) Receive training and orientation on the following:

(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 relevant continuing education each year on the topics set forth in paragraph (D)(7)(a) of this rule.

(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 consumer served that contains a copy of the initial and all subsequent all services plans, all dietary prescriptions and instructions prepared by the physician, dietitian and any other clinicians, and any additional information supporting meal delivery as specified on the all services plan.

(b) Documentation that each meal meets the RDA and DRI guidelines required by paragraphs (D)(5)(a) and (D)(5)(b) of this rule.

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

(d) Documentation from the provider that the consumer or authorized representative clearly understands how to safely reheat each meal.

(e) Documentation verifying that shelf-stable back-up meals are in the home and are replaced prior to their expiration or upon consumption.

(f) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery, time of delivery of all meals, number of meals delivered at each visit, signature or initials of the person delivering the meal and signature of the consumer or authorized representative receiving the meal(s). Nothing shall prohibit the collection or maintenance of documentation through technology-based systems. The consumer'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.

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

(h) Documentation of vehicle owner's collision and liability insurance.

(i) Documentation that the provider has established a routine delivery time with the consumer.

(j) All local health department inspection reports, and resulting plans of correction.

(k) All Ohio department of agriculture inspection reports and findings, and resulting plans of correction.

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

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

(a) Home delivered meal service providers cited for critical items during their local health department inspections shall notify the department or its designee within two business days of the citation. The provider shall immediately send to the department or its designee a copy of the inspection report, and all plans of correction and follow-up reports.

(b) Home delivered meal service providers inspected by the Ohio department of agriculture division of food safety and placed on priority or notice status shall notify the department or its designee within two business days of the issuance of the findings. The provider shall, within five business days, send to the department or its designee, a copy of the findings report and any notices issued by the Ohio department of agriculture, and all 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 shall notify the department or its designee within two business days of an action taken as defined in 9 C.F.R. 500.3 and/or 9 C.F.R. 500.4 (as in effect on the effective date of this rule). The provider shall, within five business days, send to the department or its designee, a copy of the action issued by the Ohio department of agriculture, and all resulting plans of correction and follow-up reports.

(d) The department may immediately suspend and terminate a provider's authorization to furnish home delivered meal services pursuant to Section 5111.06 of the Revised Code and rule 5101:3-1-17.6 of the Administrative Code if the department or its designee receives credible information that the provider poses a significant threat to the health and welfare of one or more consumers due to noncompliance with one or more of the requirements set forth in this rule.

~~(D) Home delivered meal services.~~

~~(1) "Home delivered meal services" are defined as the provision of individual meals to consumers. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician, taking into consideration the consumer's cultural and ethnic background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.~~

~~(2) Home delivered meals do not include services performed in excess of what is approved pursuant to the all services plan.~~

~~(3) In order to submit a claim for reimbursement, all providers of home delivered meal services must:~~

~~(a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;~~

~~(b) Possess a valid food vendor's license;~~

~~(c) Assure that all meals are prepared and delivered as identified on the all services plan; and~~

~~(d) Only submit a claim for up to two meals per day per consumer.~~

~~(4) Home delivered meal service providers must maintain the documentation identified in paragraphs (D)(4)(a) to (D)(4)(d) of this rule.~~

~~(a) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery with the time of first and last meal delivered, number of meals at each visit, initials of person delivering the meal and initials of the consumer or authorized representative receiving the meal(s).~~

~~(b) A record for each consumer served that contains a copy of the initial and all subsequent all service plans, all dietary instructions prepared by the dietician and any additional information supporting meal delivery as specified on the all services plan.~~

~~(c) All appropriate food vendor's licenses.~~

~~(d) Evidence of a time/temperature monitoring system for food preparation, handling and delivery.~~

~~(5) Upon request, home delivered meal service providers shall make available to ODJFS or its designated CMA a copy of any local health department inspection reports.~~

~~(6) Home delivered meal service providers cited for critical items during their local health department inspection shall make available a copy of that inspection report and the follow-up report to ODJFS or its designated CMA within five working days of receipt from the inspecting agent.~~

~~(7) Home delivered meal service providers cited by the Ohio department of agriculture shall make available to ODJFS or its designated CMA a copy of the findings and corresponding plans of correction within five working days of receipt from the regulatory agent.~~

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer 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 consumer to function with greater independence, avoid institutionalization and reduce the need for human assistance. They shall not exceed ~~ten~~ a total of ten thousand dollars within a twelve-month calendar ~~period~~ year per consumer. ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer'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 transitions ~~MR/DD~~ DD waiver will not pay to have the property returned to its prior condition.

(b) The need for home modification services must be identified ~~in an evaluation completed~~ by an occupational therapist or physical therapist as licensed pursuant to sections ~~4755.07~~ 4755.08 and 4755.44 of the Revised Code, during an in-person evaluation of the site to be modified, and with the consumer 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 consumer (i.e., carpeting, roof repair, central air conditioning, etc.)~~;~~.

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

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

(d) The same type of home modification for the same consumer during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the consumer'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 ~~the designated CMA~~ ODJFS or its designee and the adjustment is warranted. Family members and volunteers ~~will~~ 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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the home modification services that the provider is authorized to furnish to the consumer~~;~~.

~~(b)~~(d) ~~Assure~~ 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~~;~~.

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

~~(d)~~(f) ~~Assure~~ Provide documentation that the home modification ~~met~~ meets all applicable state and local building codes ~~and complies with the Americans with Disabilities Act (ADA);~~.

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

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

~~(f)~~(i) Obtain a final written approval from the consumer and ~~the designated CMA~~ ODJFS or its designee after completion of the home modification service.

(5) Selection of home modification service providers.

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

(b) ~~The designated CMA~~ At a minimum, ODJFS or its designee shall send the home modification specifications to every known home modification service provider in the consumer's ~~region~~ county of residence and all contiguous counties, and shall invite the submission of competitive bids. ~~The following must be submitted with all 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 5101:3-45 and 5101:3-47 of the Administrative Code.

(c) ~~The designated CMA~~ ODJFS 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 transportation services.~~

~~(1) "Supplemental transportation services" are transportation services not otherwise covered by the Ohio medicaid program that enable a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include assistance in transferring the consumer 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 the all services plan.~~

~~(3) In order to submit a claim for supplemental transportation services, the provider must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.~~

~~(4) Agency supplemental transportation service providers must:~~

~~(a) Maintain a current list of drivers;~~

~~(b) Assure 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) Assure that drivers are not the consumers' family members as that term is defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code; and~~

~~(g) Assure that drivers are not the consumers' 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) Not be the consumer's family member as that term is defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code; and~~

~~(f) Not be the consumer's foster caregiver.~~

~~(6) All supplemental transportation service providers must maintain documentation that includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip and the signature of the consumer receiving supplemental transportation services, or his or her authorized representative.~~

~~(G)~~(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 consumer, ~~or the consumer's family member as that term is defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code,~~ or a family member, or someone who resides in the same household as the consumer, that are not otherwise available through any other funding source and that are suitable to enable the consumer 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 ODJFS or its designee. ~~The designated CMA~~ ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.

(a) Reimbursement for medical equipment, ~~and~~ supplies and vehicle modifications shall not exceed a combined total of ten thousand dollars within a ~~twelve-month period~~ calendar year per consumer. ~~The designated CMA shall not approve the same type of medical equipment, supplies and devices for the same consumer for a one-year period unless there is a documented need for ongoing medical supplies or a documented change in the consumer's medical and/or physical condition requiring the replacement.~~

(b) ODJFS or its designee shall not approve the same type of medical equipment, supplies and devices for the same consumer 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 consumer's medical and/or physical condition requiring the replacement.

~~(b)~~(c) ~~Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA~~ - ODJFS or its designee shall not approve the same type of vehicle modification for the same consumer ~~for a~~ within the same three-year period, unless there is a documented change in the consumer'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 consumer'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 consumer. 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.

~~(2)~~(b) ~~Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, portable ramps, 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 consumer.~~ Prior to the authorization of a vehicle modification, the consumer and, if applicable, any other person(s) who will operate the vehicle must provide ~~the designated CMA~~ ODJFS or its designee with documentation of:

~~(a)~~(i) ~~Evidence of a~~ 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 consumer and/or other person(s) operating the vehicle;

(ii) Proof of ownership of the vehicle to be modified;

~~(b) Evidence of the successful completion of driver training from a qualified driver rehabilitation specialist or a written statement from a driver's rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other persons operating the vehicle;~~

~~(c)~~(iii) ~~Evidence of the vehicle~~ Vehicle owner's collision and liability insurance for the vehicle being modified; and

~~(d)~~(iv) A written statement from a certified mechanic stating the vehicle is in good operating condition.

~~(3)~~(c) ~~Supplemental adaptive and assistive device services~~ Vehicle modifications do not include:

~~(a) Items considered by the federal food and drug administration as experimental or investigational;~~

~~(b) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;~~

~~(c)~~(i) Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (F)(2)(a) of this rule;

~~(d)~~(ii) Routine care and maintenance of vehicle modifications and devices;

~~(e)~~(iii) Permanent modification of leased vehicles;

~~(f)~~(iv) Vehicle inspection costs;

~~(g)~~(v) Vehicle insurance costs; ~~and~~

(vi) New vehicle modifications or repair of previously-approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and

~~(h)~~(vii) Services performed in excess of what is approved pursuant to, and specified on, the consumer's all services plan.

~~(4)~~(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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the consumer~~;~~.

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

~~(c)~~(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.

~~(5)~~(4) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs ~~(G)(5)(a) to (G)(5)(d)~~ (F)(4)(a) to (F)(4)(d) of this rule.

(a) Consumer 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.

(b) Name of consumer'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.

~~(H)~~(G) Out-of-home respite services.

(1) "Out-of-home respite services" are services delivered to a consumer 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 consumer's dietary requirements.

(b) All services set forth in paragraph (~~H~~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 consumer'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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

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

~~(b)~~(d) Be either:

(i) An intermediate care facility for the mentally retarded and developmentally disabled (ICF-MR) licensed and certified in accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code; or

(ii) A nursing facility (NF) licensed and certified in accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code~~; or~~.

(iii) Another ~~institutional~~ licensed setting approved by ~~the designated CMA~~. ODJFS or its designee.

~~(c)~~(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 42 C.F.R. 80 (~~1964~~ as in effect on the effective date of this rule).

(b) Provide for coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its ~~designated CMA~~ 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 consumer served in a manner that protects the confidentiality of these records. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs (~~H~~G)(5)(a) to (~~H~~G)(5)(i) of this rule.

(a) Consumer's 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

(e) A copy of ~~the "do-not-resuscitate" (DNR) order, if one exists~~ any advance directives including, but not limited to, DNR order or medical power of attorney, if they exist.

(f) Documentation of ~~drug~~ 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 consumer, or when the consumer 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), ~~and~~ (A)(6)(j) and (A)(6)(k) of this rule when the consumer is provided waiver nursing.

(H) Emergency response services.

(1) "Emergency response services (ERS)" are emergency intervention services comprised of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the consumer 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 activation devices from which the consumer can choose in accordance with the consumer's specific needs. 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 consumer is hearing impaired, or

(iii) Audible indication of an alarm that may be appropriate if the consumer 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 consumers under the age of eighteen.

(c) Remote monitoring services.

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

(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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

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

(5) ERS requirements.

(a) Providers shall assure that all consumers 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 ERS consumer with an initial face-to-face demonstration and training on how to use their ERS equipment. Further education may be provided to the consumer, caregiver, designated responders and ODJFS or its designee upon request.

(c) Prior to, or during the delivery of ERS equipment, the provider shall work with the consumer and/or the consumer's authorized representative, and the

consumer's 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 no less than every six months.

(i) The written response plan shall include a summary of the consumer'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 consumer's designated responder. For the purposes of this rule, "designated responder" means an individual or individuals who the consumer and/or 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 and ongoing training to all designated responders prior to activation of the consumer's ERS equipment. At a minimum, the training shall include:

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

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

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

(a) If the consumer 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 consumer 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, then emergency service personnel shall be designated as the responder in the plan.

(iv) In the event a consumer sends an alarm signal but a designated responder cannot be reached, the provider shall contact emergency service personnel.

(d) Providers shall assure that emergency response centers:

(i) Employ and train staff to receive and respond to alarm signals from consumers twenty-four hours per day, three hundred and 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 ODJFS or its designee of all emergencies involving a consumer within twenty-four hours.

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

(vii) Replace malfunctioning ERS equipment within twenty-four hours of notification, and at no additional cost to the consumer, or ODJFS or its designee.

(viii) Operate all ERS lines toll-free.

(6) Providers of ERS must maintain the following documentation:

(a) A log containing the names and contact information of each consumer, and their authorized representative.

(b) A copy of each consumer's approved 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 5101:3-1-17.2 of the Administrative Code.

(d) Documentation of all consumer, 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 consumer's or authorized representative's signature verifying delivery and installation. The consumer'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 consumer's ERS equipment, including date, time and results of the test.

(g) A record of each service-related consumer contact 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 names of each person having contact with the consumer.

(h) A copy of the consumer'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 a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include, but are not limited to assistance in transferring the consumer 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 consumer'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 5101:3-45 and 5101:3-47 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-47-06 of the Administrative Code.

(c) Be identified as the provider, and have specified on, the consumer's all services plan that is prior-approved by ODJFS or its designee, the amount of supplemental transportation services the provider is authorized to furnish to the consumer.

(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 consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.

(h) Assure that drivers are not the consumer'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;

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

(f) Not be the consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.

(g) Not be the consumer's foster caregiver.

(6) All supplemental transportation service providers must maintain documentation that, at a minimum, includes a log identifying the consumer transported, the date of the service, pick-up point, destination point, mileage for each trip, and the signature of the consumer receiving supplemental transportation services, or the consumer's authorized representative. The consumer'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.

~~(I) Emergency response services.~~

~~(1) "Emergency response services (ERS)" are in-home, twenty-four-hour communication connection systems that enable a consumer at high risk of institutionalization to secure immediate assistance during a medical, physical, emotional, or environmental emergency. Consumers who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision are considered to be high risk for the purposes of this service.~~

~~(2) ERS do not include:~~

~~(a) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen; and~~

~~(b) Services performed in excess of what is approved pursuant to the all services plan.~~

~~(3) In order to submit a claim for ERS, all providers must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.~~

~~(4) Providers of ERS must:~~

~~(a) Permit consumers to select from a variety of remote activation devices;~~

~~(b) Assure that consumers have systems that meet their specific needs;~~

~~(c) Assure that emergency response systems meet all applicable quality assurance/quality control industry standards;~~

~~(d) Conduct monthly testing of emergency response systems to assure proper operation;~~

~~(e) Provide consumers, their authorized representatives, and caregivers with initial and ongoing training and assistance regarding the use of the emergency response system;~~

~~(f) Assure that the installation includes seize line circuitry guaranteeing that the emergency response system has priority over the telephone when the system is activated;~~

~~(g) Operate an emergency response center that is staffed twenty-four hours a day, three hundred sixty-five days a year to receive and respond to emergency signals;~~

~~(h) Assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;~~

~~(i) Assure that emergency response center staff respond to alarm messages within sixty seconds of receipt; and~~

~~(j) Furnish a replacement emergency response system or an activation device to the consumer within twenty-four hours of notification of a malfunction.~~

~~(5) Providers of ERS must maintain the following documentation:~~

~~(a) A log containing the names and contact information of each consumer and their authorized representatives' names and contact information;~~

~~(b) A written record of the date of delivery and installation of the emergency response system, with the consumer's or authorized representative's signature verifying delivery and installation;~~

~~(c) A record of the monthly test conducted on each consumer's emergency response system, including the date, time and results of the test; and~~

~~(d) A record documenting the date and time a consumer's emergency response system is activated and a summary of the incident and the action taken by the provider.~~

*** DRAFT – NOT FOR FILING ***

5101:3-50-04 **Transitions carve-out waiver: definitions of the covered services and provider requirements and specifications.**

This rule sets forth the definitions of the services covered by the transitions carve-out waiver. This rule also sets forth the provider requirements and specifications for the delivery of transitions carve-out waiver services. The services are reimbursed in accordance with rule 5101:3-50-06 of the Administrative Code.

(A) Waiver nursing services.

(1) "Waiver nursing services" are defined as services provided to transitions carve-out waiver consumers that require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing waiver nursing services to consumers on the transitions carve-out waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted there under, and shall possess a current, ~~and~~ valid and unrestricted license ~~in good standing~~ with the Ohio board of nursing.

(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 the 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 to be adopted there under, and to be performed by individuals 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 sole purpose of meeting the supervisory requirements as set forth in ~~paragraphs~~ paragraph (B)(6)(c) ~~and (B)(6)(d)~~ of this rule; ~~or~~

(d) Visits performed for the sole purpose of conducting an "OASIS" (outcome and assessment information set) assessment or any other assessment;

(e) Visits performed for the sole purpose of meeting the home care attendant service nurse consultation requirements set forth in rules 5101:3-46-04.1 and 5101:3-50-04.1 of the Administrative Code; or

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

(4) 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 the following requirements:

(a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

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

~~(b)~~(d) Not be the consumer's legally responsible family member as that term is defined in ~~paragraph (EE) of~~ rule 5101:3-45-01 of the Administrative Code, unless the legally responsible family member is employed by a medicare-certified, or otherwise-accredited home health agency~~;~~.

~~(c)~~(e) Not be the foster caregiver of the consumer~~;~~.

~~(d)~~(f) Be identified as the provider ~~on~~ and have specified on, the consumer's all services plan that is prior-approved by ~~the designated case management agency (CMA);~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish waiver nursing services to the consumer.

~~(e)~~(g) Be identified as the provider on, and be performing nursing services pursuant to ~~signed and dated written orders from the treating physician; and~~ the consumer's plan of care, as that term is defined in rule 5101:3-45-01 of the Administrative Code. The plan of care must be signed and dated by the consumer's treating physician.

~~(f)~~(h) Be providing the service for one individual, or for up to three individuals in a group setting, during a face-to-face nursing visit.

(5) 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

(b) Conduct a face-to-face visit with the consumer and the directing RN ~~no less than~~ prior to initiating services and at least every one hundred twenty days

for the purpose of evaluating the provision of waiver nursing services, the consumer'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.

(6) All waiver nursing service providers must maintain a clinical record for each consumer 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 consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs (A)(6)(a) to (A)(6)(~~k~~l) of this rule.

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer'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 consumer'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 the face-to-face visits between the LPN and the directing RN, and documenting the face-to-face visits between the LPN, the consumer 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 ~~the~~ any advance directives including, but not limited to, "do not resuscitate" (DNR) order or medical power of attorney, if ~~one exists~~ they exist.

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

~~(i)~~(j) ~~Clinical notes, signed and dated by the nurse, documenting the services performed during, and outcomes resulting from, each nursing visit. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.~~ Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or 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 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.

~~(j)~~(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.

~~(k)~~(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 consumer, or when the consumer 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 transitions carve-out waiver's all services plan that assist the consumer with activities of daily living (ADL) and instrumental activities of daily living (IADL) ~~impairments~~ needs. If the 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 consists of the services listed in paragraphs (B)(1)(a) to (B)(1)(e) of this rule. ~~Personal care aide service providers may elect not to furnish one or more of the listed services.~~ If the provider ~~so elects,~~ cannot perform IADLs, the provider must notify ~~the designated CMA~~ ODJFS or its designee, in writing, of the ~~services the provider elects not to furnish~~ service limitations prior to inclusion on the 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 consumer; and

(e) Accompanying or transporting the consumer to transitions carve-out waiver services, medical appointments, other community services, or running errands on behalf of the consumer.

(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 consumer, but may, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph (~~B~~C) of rule ~~4723-13-04~~ 4723-13-02 of the Administrative Code, help the consumer self-administer medications by:

(a) Reminding the consumer when to take the medication, and observing to ensure the consumer follows the directions on the container;

(b) Assisting the consumer by taking the medication in its container from where it is stored and handing the container to the consumer;

(c) Opening the container for a consumer who is physically unable to open the container;

(d) Assisting a consumer 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 a consumer 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 consumer.

(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 individuals providing personal care aide services must meet the following:

(a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

~~(a)~~(c) Be at least eighteen years of age~~;~~.

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

~~(c)~~(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~~;~~.

~~(d)~~(f) Not be the consumer's legally responsible family member as that term is defined in ~~paragraph (EE) of~~ rule 5101:3-45-01 of the Administrative Code~~;~~.

~~(e)~~(g) Not be the foster caregiver of the consumer~~;~~.

~~(f)~~(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~~; and~~.

~~(g)~~(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 ~~home health~~ agencies must assure that personal care aides meet the following requirements:

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

(i) Obtain a certificate of completion of either ~~the nurse aide~~ 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 ~~47~~ 42 C.F.R. 484 (~~2005~~as in effect on the effective date of this rule), 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 ~~eight~~ twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately ~~after the personal care aide's first anniversary of employment with the agency~~, 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 consumer home visit explaining the expected activities of the personal care aide, and identifying the consumer's personal care aide services.

(ii) Conduct a face-to-face consumer home visit at least every sixty days ~~after the initial visit~~ while the personal care aide is present and providing care to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery, and personal care aide performance. The visit must be documented in the consumer's record.

~~(iii) Conduct a face-to-face consumer home visit at least every one hundred twenty days while the personal care aide is present and providing care. The visit must be documented in the consumer's record.~~

~~(iv)~~(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 transitions carve-out waiver.

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

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

(a) Prior to commencing service delivery personal care aides must have:

(i) Obtained a certificate of completion within the last twenty-four months for either ~~the nurse aide~~ 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 ~~47~~ 42 C.F.R. 484 (~~2005~~as in effect on the effective date of this rule); 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 ~~infection control~~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 ~~eight~~ 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 consumer 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.

(c) Comply with the consumer's or the consumer's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the consumer or the case manager.

(d) Comply with ODJFS monitoring requirements in accordance with rule ~~5101:3-12-30~~ 5101:3-45-06 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 transitions carve-out waiver.

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

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

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

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

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

(g) ~~Documentation that clearly shows the date of service delivery, the personal care aide service tasks performed or not performed, the arrival and departure times, and the signatures of the personal care aide and consumer or authorized representative upon completion of service delivery. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.~~ Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or 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

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 CM, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.

(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 consumer, or when the consumer no longer needs personal care aide services. The summary should include documentation regarding progress made toward achievement of goals as specified on the consumer'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 consumers age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that ~~is used solely for the provision of ADHCS.~~ shall not be used for other purposes during the provision of ADHCS.

(a) The services the adult day health center must ~~make available~~ 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) ~~No~~ At least one, but no more than two meals per day that meet the consumer'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 5101:3-12-01 of the Administrative Code;

(ii) Transportation of the consumer to and from ADHCS.

(c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to a consumer in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided to a consumer on 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 consumer'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 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider on the consumer's all services plan that is prior-approved by ~~the designated CMA; and~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish ADHCS to the consumer.

~~(b)~~(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 42 C.F.R. 80 (~~1964~~as in effect on the effective date of this rule).

(b) Provide for replacement coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its ~~designated CMA~~ designee - verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of ~~eight~~ - twelve 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 ~~limited~~ 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~~ set forth in paragraph (B)(1) of this rule.

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

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

(a) Consumer 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

(e) A copy of ~~the "do-not-resuscitate" (DNR) order, if one exists~~ any advance directive including, but not limited to, DNR order or medical power of attorney, if they exist.

(f) Documentation of ~~drug~~ 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 consumer's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by the 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 consumer, or when the consumer 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), ~~and~~ (A)(6)(j) and (A)(6)(k) of this rule when the consumer 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 a consumer 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 a consumer at his or her home. A consumer may be authorized to receive up to two home delivered meals per day.

(2) Home delivered meals:

(a) Shall be planned and approved, in writing, by a dietitian, taking into consideration the consumer's medical restrictions, religious, cultural and ethnic background and dietary preferences.

(b) Shall be prepared by a provider who is in compliance with the food preparation and food safety requirements set forth in Chapters 918, 3715 and 3717 of the Revised Code, as appropriate, and 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.

(c) Shall be individually packaged.

(d) Shall include at least two shelf-stable meals that serve as back-up in case an emergency prevents planned meal delivery. Back-up meals shall be furnished at no cost to the department, its designee, or the consumer or authorized representative.

(e) May include a therapeutic diet that requires a daily amount or distribution of one or more specified nutrients in order to treat a disease or clinical condition, or eliminate, decrease or increase certain substances in the consumer's diet. Authorization must be documented in the consumer's clinical record every sixty days.

(3) Home delivered meals shall not:

(a) Include services or activities performed in excess of what is approved on the consumer'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 prepared while the consumer 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 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of home delivered meal services in accordance with rule 5101:3-50-06 of the Administrative Code.

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

(d) Possess a current food service operation license and maintain copies of all inspection reports from the Ohio department of agriculture, as required.

(e) Possess all other applicable licenses or certificates, and maintain copies of all related reports, as required.

(f) Assure that all meals are prepared and delivered as identified on the consumer's all services plan.

(g) Submit claims that do not exceed two meals per day per consumer.

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

(a) Meet current recommended dietary allowances (RDA) and dietary reference intakes (RDI) established by the food and nutrition board of the institute of medicine of the national academy of sciences.

(b) Comply with one-third of the current dietary guidelines for Americans as published by the United States department of health and human services and the United States 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 consumer's all services plan.

(a) All food items must be labeled with an expiration date.

(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 custom-built, temperature-controlled food delivery vehicle, the provider must maintain verification of testing meal temperatures at least monthly. When using other food delivery vehicles, the provider must maintain verification of testing meal temperatures at least weekly.

(e) The provider must establish a routine delivery time with the consumer and notify the consumer 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 ensure that the consumer or authorized representative clearly understands how to safely reheat each meal.

(h) Verification that shelf-stable back-up meals are in the home and are replaced prior to their expiration date or upon consumption.

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

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

(i) Receive training and orientation on the following:

(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 relevant continuing education each year on the topics set forth in paragraph (D)(7)(a) of this rule.

(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 consumer served that contains a copy of the initial and all subsequent all services plans, all dietary prescriptions and instructions prepared by the physician, dietitian and any other clinicians, and any additional information supporting meal delivery as specified on the all services plan.

(b) Documentation that each meal meets the RDA and DRI guidelines required by paragraphs (D)(5)(a) and (D)(5)(b) of this rule.

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

(d) Documentation from the provider that the consumer or authorized representative clearly understands how to safely reheat each meal.

(e) Documentation verifying that shelf-stable back-up meals are in the home and are replaced prior to their expiration or upon consumption.

(f) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery, time of delivery of all meals, number of meals delivered at each visit, signature or initials of the person delivering the meal and the signature of the consumer or authorized representative receiving the meal(s). Nothing shall prohibit the collection or maintenance of documentation through technology-based systems. The consumer'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.

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

(h) Documentation of vehicle owner's collision and liability insurance.

(i) Documentation that the provider has established a routine delivery time with the consumer.

(j) All local health department inspection reports, and resulting plans of correction.

(k) All Ohio department of agriculture inspection reports and findings, and resulting plans of correction.

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

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

(a) Home delivered meal service providers cited for critical items during their local health department inspections shall notify the department or its designee within two business days of the citation. The provider shall immediately send to the department or its designee a copy of the inspection report, and all plans of correction and follow-up reports.

(b) Home delivered meal service providers inspected by the Ohio department of agriculture division of food safety and placed on priority or notice status shall notify the department or its designee within two business days of the issuance of the findings. The provider shall, within five business days, send to the department or its designee, a copy of the findings report and any notices issued by the Ohio department of agriculture, and all 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 shall notify the department or its designee within two business days of an action taken as defined in 9 C.F.R. 500.3 and/or 9 C.F.R. 500.4 (as in effect on the effective date of this rule). The provider shall, within five business days, send to the department or its designee, a copy of the action issued by the Ohio department of agriculture, and all resulting plans of correction and follow-up reports.

(d) The department may immediately suspend and terminate a provider's authorization to furnish home delivered meal services pursuant to Section 5111.06 of the Revised Code and rule 5101:3-1-17.6 of the Administrative Code if the department or its designee receives credible information that the provider poses a significant threat to the health and welfare of one or more consumers due to noncompliance with one or more of the requirements set forth in this rule.

~~(D) Home delivered meal services.~~

~~(1) "Home delivered meal services" are defined as the provision of individual meals to consumers. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician,~~

~~taking into consideration the consumer's cultural and ethnic background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.~~

~~(2) Home delivered meals do not include services performed in excess of what is approved pursuant to the all services plan.~~

~~(3) In order to submit a claim for reimbursement, all providers of home delivered meal services must:~~

~~(a) Be identified as the provider on the consumer's all services plan that is prior approved by the designated CMA;~~

~~(b) Possess a valid food vendor's license;~~

~~(c) Assure that all meals are prepared and delivered as identified on the all services plan; and~~

~~(d) Only submit a claim for up to two meals per day per consumer.~~

~~(4) Home delivered meal service providers must maintain the documentation identified in paragraphs (D)(4)(a) to (D)(4)(d) of this rule.~~

~~(a) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery with the time of first and last meal delivered, number of meals at each visit, initials of person delivering the meal and initials of the consumer or authorized representative receiving the meal(s).~~

~~(b) A record for each consumer served that contains a copy of the initial and all subsequent all service plans, all dietary instructions prepared by the dietician and any additional information supporting meal delivery as specified on the all services plan.~~

~~(c) All appropriate food vendor's licenses.~~

~~(d) Evidence of a time/temperature monitoring system for food preparation, handling and delivery.~~

~~(5) Upon request, home delivered meal service providers shall make available to ODJFS or its designated CMA a copy of any local health department inspection reports.~~

~~(6) Home delivered meal service providers cited for critical items during their local health department inspection shall make available a copy of that inspection~~

~~report and the follow-up report to ODJFS or its designated CMA within five working days of receipt from the inspecting agent.~~

~~(7) Home delivered meal service providers cited by the Ohio department of agriculture shall make available to ODJFS or its designated CMA a copy of the findings and corresponding plans of correction within five working days of receipt from the regulatory agent.~~

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer 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 consumer to function with greater independence, avoid institutionalization and reduce the need for human assistance. They shall not exceed ~~ten~~ a total of ten thousand dollars within a twelve-month calendar year ~~period~~ per consumer. ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer'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 transitions carve-out waiver will not pay to have the property returned to its prior condition.

(b) The need for home modification services must be identified ~~in an evaluation completed~~ by an occupational therapist or physical therapist as licensed pursuant to sections ~~4755.07~~ 4755.08 and 4755.44 of the Revised Code, during an in-person evaluation of the site to be modified, and with the consumer 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 consumer (i.e., carpeting, roof repair, central air conditioning, etc.)~~;~~.

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

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

(d) The same type of home modification for the same consumer during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the consumer'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 ~~the designated CMA~~ ODJFS or its designee and the adjustment is warranted. Family members and volunteers ~~will~~ 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 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA;~~ ODJFS or its designee, the home modification services that the provider is authorized to furnish to the consumer.

~~(b)~~(d) ~~Assure~~ 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~~;~~.

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

~~(d)~~(f) ~~Assure~~ Provide documentation that the home modification met all applicable state and local building codes ~~and complies with the Americans with Disabilities Act (ADA);~~.

(g) Provide documentation that the home modification meets the consumer's needs and complies with the Americans with Disabilities Act (ADA) (as in effect on the effective date of this rule), the Uniform Federal Accessibility Standards (UFAS) (as in effect on the effective date of this rule) or the Fair

Housing Act (FHA) (as in effect on the effective date of this rule), as applicable. If a home modification must be customized in order to meet the consumer's needs, and that customization will not be compliant with the ADA, UFAS or FHA, it must be prior-approved by ODJFS or its designee, in consultation with the consumer and/or authorized representative and the consumer's interdisciplinary team.

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

~~(f)~~(i) Obtain a final written approval from the consumer and ~~the designated CMA~~ ODJFS or its designee after completion of the home modification service.

(5) Selection of home modification service providers.

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

(b) ~~The designated CMA~~ At a minimum, ODJFS or its designee shall send the home modification specifications to every known home modification service provider in the consumer's ~~region~~ county of residence and all contiguous counties, and shall invite the submission of competitive bids. ~~The following must be submitted with all 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 5101:3-45 and 5101:3-50 of the Administrative Code..

(c) ~~The designated CMA~~ ODJFS 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 transportation services.~~

~~(1) "Supplemental transportation services" are transportation services not otherwise covered by the Ohio medicaid program that enable a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include assistance in transferring the consumer 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 the all services plan.~~

~~(3) In order to submit a claim for supplemental transportation services, the provider must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.~~

~~(4) Agency supplemental transportation service providers must:~~

~~(a) Maintain a current list of drivers;~~

~~(b) Assure 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) Assure that drivers are not the consumers' legally responsible family members as that term is defined in paragraph (EE) of rule 5101:3-45-01 of the Administrative Code; and~~

~~(g) Assure that drivers are not the consumers' 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) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule 5101:3-45-01 of the Administrative Code; and~~

~~(f) Not be the consumer's foster caregiver.~~

~~(6) All supplemental transportation service providers must maintain documentation that includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip and the signature of the consumer receiving supplemental transportation services, or his or her authorized representative.~~

~~(G)~~(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 consumer, ~~or the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule 5101:3-45-01 of the Administrative Code,~~ or a family member, or someone who resides in the same household as the consumer, that are not otherwise available through any other funding source and that are suitable to enable the consumer to function with greater independence, avoid institutionalization, and reduce the need for human assistance. ~~The designated CMA~~ All supplemental adaptive and assistive device services shall be prior-approved by ODJFS or its designee. ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.

(a) Reimbursement for medical equipment, ~~and~~ supplies and vehicle modifications shall not exceed a combined total of ten thousand dollars within a ~~twelve-month period~~ calendar year per consumer. ~~The designated~~

~~CMA shall not approve the same type of medical equipment, supplies and devices for the same consumer for a one year period unless there is a documented need for ongoing medical supplies or a documented change in the consumer's medical and/or physical condition requiring the replacement.~~

(b) ODJFS or its designee shall not approve the same type of medical equipment, supplies and devices for the same consumer during the same calendar year, unless there is a documented need for ongoing medical equipment, or a documented change in the consumer's medical and/or physical condition requiring the replacement.

~~(b)~~(c) ~~Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve month period per consumer. The designated CMA~~ - ODJFS or its designee shall not approve the same type of vehicle modification for the same consumer ~~for a~~ within the same three-year period, unless there is a documented change in the consumer'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 consumer'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 consumer. 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.

~~(2)~~(b) ~~Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, portable ramps, 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 consumer.~~ Prior to the authorization of a vehicle modification, the consumer and, if applicable, any other person(s) who will operate the vehicle must provide the ~~designated CMA~~ ODJFS or its designee with documentation of:

~~(a)~~(i) ~~Evidence of a~~ 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 consumer and/or other person(s) operating the vehicle;

(ii) Proof of ownership of the vehicle to be modified;

~~(b) Evidence of the successful completion of driver training from a qualified driver rehabilitation specialist or a written statement from a driver's rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other persons operating the vehicle;~~

~~(c)~~(iii) ~~Evidence of the vehicle~~ Vehicle owner's collision and liability insurance for the vehicle being modified; and

~~(d)~~(iv) A written statement from a certified mechanic stating the vehicle is in good operating condition.

~~(3)~~(c) ~~Supplemental adaptive and assistive device services~~ Vehicle modifications do not include:

~~(a) Items considered by the federal food and drug administration as experimental or investigational;~~

~~(b) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;~~

~~(c)~~(i) Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (F)(2)(a) of this rule;

~~(d)~~(ii) Routine care and maintenance of vehicle modifications and devices;

~~(e)~~(iii) Permanent modification of leased vehicles;

~~(f)~~(iv) Vehicle inspection costs;

~~(g)~~(v) Vehicle insurance costs; ~~and~~

(vi) New vehicle modifications or repair of previously-approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and

~~(h)~~(vii) Services performed in excess of what is approved pursuant to, and specified on, the consumer's all services plan.

~~(4)~~(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 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the consumer.~~;~~

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

~~(c)~~(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.

~~(5)~~(4) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. ~~The~~ At a minimum, the clinical record must contain the information listed in paragraphs ~~(G)(5)(a) to (G)(5)(d)~~ (F)(4)(a) to (F)(4)(d) of this rule.

(a) Consumer 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.

(b) Name of consumer'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.

~~(H)~~(G) Out-of-home respite services.

(1) "Out-of-home respite services" are services delivered to a consumer 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 consumer's dietary requirements.

(b) All services set forth in paragraph (~~H~~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 consumer'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 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

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

~~(b)~~(d) Be either:

(i) An intermediate care facility for the mentally retarded and developmentally disabled (ICF-MR) licensed and certified in

accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code; or

(ii) A nursing facility (NF) licensed and certified in accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code; or

(iii) Another ~~institutional~~ licensed setting approved by ~~the designated CMA~~ ODJFS or its designee.

~~(c)~~(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 42 C.F.R. 80 (~~1964~~ as in effect on the effective date of this rule).

(b) Provide for coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its ~~designated CMA~~ 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 consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in paragraphs (~~H~~G)(5)(a) to (~~H~~G)(5)(i) of this rule.

(a) Consumer's 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.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

(e) A copy of ~~the "do-not-resuscitate" (DNR) order, if one exists~~ any advance directives including, but not limited to, DNR order or medical power of attorney, if they exist.

(f) Documentation of ~~drug~~ 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 consumer, or when the consumer no longer needs out-of-home respite services.

(i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i), ~~and~~ (A)(6)(j) and (A)(6)(k) of this rule when the consumer is provided waiver nursing.

(H) Emergency response services.

(1) "Emergency response services (ERS)" are emergency intervention services comprised of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the consumer 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 activation devices from which the consumer can choose in accordance with the consumer's specific needs. 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 consumer is hearing impaired, or

(iii) Audible indication of an alarm that may be appropriate if the consumer 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 consumers under the age of eighteen.

(c) Remote monitoring services.

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

(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 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

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

(5) ERS requirements.

(a) Providers shall assure that all consumers 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 ERS consumer with an initial face-to-face demonstration and training on how to use their ERS equipment. Further education may be provided to the consumer, caregiver, designated responders and ODJFS or its designee upon request.

(c) Prior to, or during the delivery of ERS equipment, the provider shall work with the consumer and/or the consumer's authorized representative, and the consumer's 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 no less than every six months.

(i) The written response plan shall include a summary of the consumer'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 consumer's designated responder. For the purposes of this rule, "designated responder" means an individual or individuals who the consumer and/or 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 and ongoing training to all designated responders prior to activation of the consumer's ERS equipment. At a minimum, the training shall include:

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

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

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

(a) If the consumer 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 consumer 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, then emergency service personnel shall be designated as the responder in the plan.

(iv) In the event a consumer sends an alarm signal but a designated responder cannot be reached, the provider shall contact emergency service personnel.

(d) Providers shall assure that emergency response centers:

(i) Employ and train staff to receive and respond to alarm signals from consumers twenty-four hours per day, three hundred and 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 ODJFS or its designee of all emergencies involving a consumer within twenty-four hours.

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

(vii) Replace malfunctioning ERS equipment within twenty-four hours of notification, and at no additional cost to the consumer, or ODJFS or its designee.

(viii) Operate all ERS lines toll-free.

(6) Providers of ERS must maintain the following documentation:

(a) A log containing the names and contact information of each consumer, and their authorized representative.

(b) A copy of each consumer's approved 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 5101:3-1-17.2 of the Administrative Code.

(d) Documentation of all consumer, 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 consumer's or authorized representative's signature verifying delivery and installation. The consumer'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 consumer's ERS equipment, including date, time and results of the test.

(g) A record of each service-related consumer contact 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 names of each person having contact with the consumer.

(h) A copy of the consumer'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 a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include, but are not limited to assistance in transferring the consumer 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 consumer'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 5101:3-45 and 5101:3-50 of the Administrative Code.

(b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.

(c) Be identified as the provider, and have specified on, the consumer's all services plan that is prior-approved by ODJFS or its designee, the amount of supplemental transportation services the provider is authorized to furnish to the consumer.

(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 consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.

(h) Assure that drivers are not the consumer'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;

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

(f) Not be the consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.

(g) Not be the consumer's foster caregiver.

(6) All supplemental transportation service providers must maintain documentation that, at a minimum, includes a log identifying the consumer transported, the date of the service, pick-up point, destination point, mileage for each trip, and the signature of the consumer receiving supplemental transportation services, or the consumer's authorized representative. The consumer'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.

~~(I) Emergency response services.~~

~~(1) "Emergency response services (ERS)" are in-home, twenty-four-hour communication connection systems that enable a consumer at high risk of institutionalization to secure immediate assistance during a medical, physical, emotional, or environmental emergency. Consumers who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision are considered to be high risk for the purposes of this service.~~

~~(2) ERS do not include:~~

~~(a) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen; and~~

~~(b) Services performed in excess of what is approved pursuant to the all services plan.~~

~~(3) In order to submit a claim for ERS, all providers must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.~~

~~(4) Providers of ERS must:~~

~~(a) Permit consumers to select from a variety of remote activation devices;~~

~~(b) Assure that consumers have systems that meet their specific needs;~~

~~(c) Assure that emergency response systems meet all applicable quality assurance/quality control industry standards;~~

~~(d) Conduct monthly testing of emergency response systems to assure proper operation;~~

~~(e) Provide consumers, their authorized representatives, and caregivers with initial and ongoing training and assistance regarding the use of the emergency response system;~~

~~(f) Assure that the installation includes seize line circuitry guaranteeing that the emergency response system has priority over the telephone when the system is activated;~~

~~(g) Operate an emergency response center that is staffed twenty-four hours a day, three hundred sixty-five days a year to receive and respond to emergency signals;~~

~~(h) Assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;~~

~~(i) Assure that emergency response center staff respond to alarm messages within sixty seconds of receipt; and~~

~~(j) Furnish a replacement emergency response system or an activation device to the consumer within twenty-four hours of notification of a malfunction.~~

~~(5) Providers of ERS must maintain the following documentation:~~

~~(a) A log containing the names and contact information of each consumer and their authorized representatives' names and contact information;~~

~~(b) A written record of the date of delivery and installation of the emergency response system, with the consumer's or authorized representative's signature verifying delivery and installation;~~

~~(c) A record of the monthly test conducted on each consumer's emergency response system, including the date, time and results of the test; and~~

~~(d) A record documenting the date and time a consumer's emergency response system is activated and a summary of the incident and the action taken by the provider.~~