Common Sense Initiative

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Business Impact Analysis

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

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Regulation/Package Title (a general description of the rules' substantive content):

State Plan Home Health and Private Duty Nursing Rescinded and New Rules

Rule Number(s): 5160-12-02.3 (rescind/new), 5160-12-03 (rescind/new), 5160-12-03.1 (rescind/new)

Date of Submission for CSI Review: 5/23/2025

Public Comment Period End Date: 5/30/2025

Rule Type/Number of Rules:

New/ 3 rules
No Change/ ____ rules (FYR? ___)
Amended/ ____ rules (FYR? ___)
Rescinded/ 3 rules (FYR? Y)

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

Reason for Submission

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

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

   The rule(s):

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

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

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

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

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**

   Home health and Private Duty Nursing (PDN) are state plan services offered by the Ohio Department of Medicaid (ODM) to eligible individuals. These services assist individuals who reside in their home, who without the provision of these services could be required to be in a hospital or nursing facility. "Home health services" includes home health nursing, home health aide services and skilled therapies. "Private duty nursing (PDN)" is a continuous nursing service that requires the skills of and is performed by either a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of a registered nurse. Both home health and PDN services are available to any Medicaid recipient throughout Ohio.

   In this rule package, home health and PDN rules 5160-12-2.3, 5160-12.3, and 5160-12.3.1 of the Administrative Code will all be rescinded, and a new rule will be put in place for each rule matter due to the large number of changes; however, they will be replaced with the same rule number and general subject matter. These changes will improve the prior authorization process for PDN and outline the rules and guidelines to become a home health or PDN provider. Additional changes will be made to improve clarity and decrease the redundancy of items already in federal law or provider contracts. Also, errors were corrected to reflect accurate rule citations.

Rescinded/New Rules to be Proposed

OAC 5160-12-02.3, "Private duty nursing: procedures for service authorization" was reviewed as part of the five-year rule review and will be proposed as rescind/new as more than fifty percent was the rule requires amendment. This rule will be replaced with the same title and number. Also, the subject matter of this rule will remain the same. This rule specifies the provisions that govern PDN services and who completes the prior authorization for services. This rule was reformatted to allow easier comprehension and decrease redundancy.

Within 5160-12-02.3, paragraph (B) will be replaced with the process for submitting a request for PDN is dependent on the individual's home and community-based services (HCBS) waiver enrollment and service payer, as follows:

- Paragraphs (B)(1) to (B)(5) Prior authorization for all payor and waivers are listed separately by designee to allow for quick reference to prior authorization procedures.
- Paragraphs (C) to (G) will not be replaced but shifted and streamlined. We will remove duplication of text throughout the document.

OAC 5160-12-03, "Medicare certified home health agencies: qualifications and requirements" was reviewed as part of the five-year rule review and proposed for recission as more than fifty percent was the rule requires amendment. This rule will be replaced with a new rule with the same number; however, the title will be changed to "Home health service providers" to make a clear distinction between requirements for home health providers and private duty nursing providers. The general subject matter of this rule remains the same. Rule 5160-12-03 describes the requirements for a Medicare certified home health agencies (MCHHA) to provide home health services in Ohio. The requirement of being "certified by the Ohio department of health" will be corrected to "licensed by the Ohio department of health (ODH)" in accordance with Chapter 3701-60 of the Administrative Code to differentiate between the certification and licensure needed. All other changes to the rule were removal of redundant language that can be already found in federal rule or the provider agreements.

OAC 5160-12-03.1, "Non-agency nurses and otherwise-accredited agencies: qualifications and requirements" was reviewed as part of the five-year rule review and is will be proposed for recission as more than fifty percent was the rule requires amendment. This rule will be replaced with a new rule with the same number; however, the new title will be "Private duty nursing service providers." The general subject matter of this rule remains the same. This rule sets forth the qualifications and requirements for medicare certified home health agencies, non-agency nurses and nurses employed by an otherwise-accredited agency to provide PDN services. The change in OAC title is to improve clarity among those home health and PDN providers and the requirement differences. The biggest difference being that Medicare certified home health agencies can provide PDN services so that language has been added to the new rule.

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

   RC 5164.02

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

   Yes. The regulations to be modified and proposed will enable Ohio to maintain approval to administer and enforce the State Plan Medicaid home health and private duty nursing services pursuant to federally imposed requirements. These requirements are listed in 2 CFR 440.80 and 2 CFR 440.70.

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

   The rules will be consistent with federal requirements; however, it includes a prior authorization process that is not specifically required by CMS. This prior authorization process allows Medicaid or its designee to assess medical necessity for private duty nursing.

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

   OAC rules 5160-12-02.3, 5160-12-03, 5160-12-03.1 are necessary for the statewide administration of Medicaid home health and private duty nursing services. They enable ODM to comply with federal requirements and ensure the appropriate level of safety and statewide compliance for home health and PDN providers. Home health and private duty nursing service providers need to be qualified and maintain core standards when providing services.

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

   The success of these regulations will be measured by the safe and effective provision of home health and private duty nursing services furnished by qualified providers who can effectively meet the needs of Medicaid recipients. These regulations will be aimed to improve clarity for providers and allow for needs to be met more efficiently.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**

If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation. No.

Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**

   -Ohio Department of Aging

   -Ohio Department of Developmental Disabilities

   -Ohio Council for Home Care and Hospice

   -Ohio Department of Medicaid- Managed Care Plans

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

    The Ohio Department of Medicaid has an existing relationship with stakeholders affiliated with the provision of home health and private duty nursing services in the state. The Department of Aging, Department of Developmental Disabilities, and Ohio Council for Home Care and Hospice all reviewed the to be proposed rule changes and provided feedback in multiple sessions. The draft changes were made to improve the clarity of completing a prior authorization for private duty nursing, as well as, how to become a provider of home health and private duty nursing services. Part of the restructuring was to remove unnecessary duplication and improve clarity per stakeholders' response.

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

    Scientific data was not applicable as it pertains to the development of these rules.

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

    None. Alternative regulations were not considered by the Ohio Department of Medicaid as the requirements of these rules will be dictated by federal and state laws and regulations.

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

    These rules have been reviewed by policy development staff, as well has at the Ohio Department of Medicaid. Where possible, existing OAC requirements were incorporated by reference and consistent standards were maintained

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

Written correspondence will be sent to providers and other stakeholders explaining the changes that have been made to these rules. Additionally, the final rules will be made available to stakeholders and the public on the Ohio Department of Medicaid's website.

Adverse Impact to Business

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

a. Identify the scope of the impacted business community.

As of July 1, 2024, there were 2,668 providers of home health and/or private duty nursing services in Ohio. This includes medicare certified home health agencies, other accredited agencies, and independent nurse providers, and is broken down as follows:

a. 801 medicare certified home health providers

b. 100 other accredited agencies

c. 1,767 independent nurses

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

1. OAC 5160-12-02.3: The provider will need to notify ODM or its designee if emergency PDN services are delivered immediately or no later than the first business day following the emergency provision.

2. OAC 5160-12-03: This rule will require agencies to be certified as a medicare certified home health agency provider (MCHHA) and for the MCHHA to execute provider agreements as a condition of participation and compliance. Providers of home health services are also required to be licensed by the Ohio department of health (ODH). Home health providers are also required to notify the individual if the regularly scheduled staff cannot or do not meet their obligation to provide services. The following are the costs associated with becoming a MCHHA:

    a. $250 application fee, Ohio Department of Health
    b. $730 application fee, Centers for Medicare and Medicaid Services
    c. Skilled home health services surety bond in the amount of $50,000

d. Any cost associated with additional accreditation would be based on the size, complexity, number (and/or type) of services, and patient capacity of your agency
e. Start-up costs for creating a business entity, liability insurance, documentation and medical records system, hiring and training staff members would be based on size, location, number (and/or type) of services, and patient capacity of your agency

3. OAC 5160-12-03.1: Private duty nursing (PDN) services must be provided by a MCHHA, otherwise-accredited agencies, or by a non-agency nurse. All provider types must have a registered nurse or licensed practical nurse at the direction of a registered nurse practicing within the scope of his or her nursing license performing PDN services. The following are the costs associated with becoming a PDN provider:
    a. For MCHHA providers, please refer to paragraph (15)(3)(b).
    b. For other accredited providers, accreditation would be based on the size, complexity, number (and/or type) of services, and patient capacity of your agency
    c. For independent nurses, the licensure fee associated with becoming an RN or LPN is $75.

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

No proposed changes to these rules reduced regulatory burden; however, we do expect there to be improved clarity and efficiency for certain home health and private duty nursing processes.

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

Home health and private duty nursing are offered as part of Ohio's state plan services and as are subject to certain requirements. It is a CMS regulation that all Medicaid home health providers be medicare certified. Private duty nursing providers need to be a registered nurse or licensed practical nurse at the direction of a registered nurse practicing within the scope of his or her nursing license.

Regulatory Flexibility

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

No. The provisions in these rules are mandatory for all Home Health and PDN services providers.

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

ORC section 119.14 is not applicable to these rules.

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

Providers in need of assistance may contact the Bureau of Long-Term Care Services and Supports, through the Provider Relations Hotline at (800) 686-1516.

RESCINDED - NOT FOR FILING

5160-12-02.3 Private duty nursing: procedures for service authorization.

(A) As a prerequisite to receiving private duty nursing (PDN) services, an individual must meet the requirements set forth in rule 5160-12-02 of the Administrative Code, as applicable, which require the individual to receive PDN authorization from the Ohio department of medicaid (ODM) or its designee.

(B) The procedures set forth in this paragraph must be followed when securing a PDN authorization for individuals who are not enrolled on a home and community-based services (HCBS) waiver.

(1) The PDN provider shall submit a referral for PDN authorization to ODM using the ODM 02374, "Private Duty Nursing (PDN) Services Request" (3/2015), along with any additional supporting documentation requested by ODM.

(2) ODM shall conduct an in-person assessment and/or perform a desk review to determine if, in accordance with rule 5160-12-02 of the Administrative Code, the individual has a medical condition that meets the criteria for an comparable institutional level of care, including a nursing facility-based level of care, and the services are medically necessary as set forth in rule 5160-1-01 of the Administrative Code.

(a) If ODM determines the individual has a medical condition that meets the criteria for a nursing facility-based level of care, and PDN services are medically necessary as set forth in rule 5160-1-01 of the Administrative Code, ODM shall:

(i) Notify the PDN provider in writing of the authorized amount, scope and duration of PDN services and the PDN authorization number. The PDN provider shall begin furnishing PDN services to the individual upon receipt of written PDN authorization and in accordance with all other requirements set forth in rule 5160-12-02 of the Administrative Code.

(ii) Inform the individual of the PDN authorization, specifying the authorized amount, scope and duration of PDN services.

(b) If the individual disagrees with the authorized amount, scope and/or duration of PDN services, the individual may request a hearing in accordance with division 5101:6 of the Administrative Code.

(c) If ODM determines the individual does not have a medical condition that meets the criteria for an institutional level of care, including a nursing facility-based level of care, and/or the services are not medically necessary as set forth in rule 5160-1-01 of the Administrative Code, ODM:

(i) May conduct an additional review of the PDN authorization request that has been proposed for denial, and/or

(ii) Shall deny the PDN authorization request, and issue a denial notice and hearing rights to the individual in accordance with division 5101:6 of the Administrative Code, and

(iii) Shall notify the PDN provider in writing of the denial of the PDN authorization request.

(3) The provider shall notify ODM in writing using the ODM 02374 when there is any change in the individual's condition that the provider believes may warrant a change in the amount, scope or duration of PDN services.

(C) The procedures set forth in this paragraph must be followed when securing a PDN authorization for individuals enrolled on an HCBS waiver administered by the Ohio department of aging (ODA) if applicable

for an adult. The period for which PDN authorization applies shall not exceed three hundred sixty-five days.

(1) The individual, or PDN provider shall request that the ODA case manager if applicable, submit a referral for PDN authorization to ODM using the ODM 02374 along with any additional supporting documentation requested by ODM. The case manager shall assist the individual in securing a potential PDN service provider.

(2) ODM shall conduct an in-person assessment and/or perform a desk review to determine if, in accordance with rule 5160-12-02 of the Administrative Code, the individual is enrolled on an ODA administered waiver as applicable for an adult, and has a medical condition that requires PDN services that are medically necessary in accordance with rule 5160-1-01 of the Administrative Code.

(a) If ODM determines, in accordance with rule 5160-12-02 of the Administrative Code, the individual is enrolled on an ODA administered waiver, and has a medical condition that requires PDN services that are medically necessary in accordance with rule 5160-1-01 of the Administrative Code, ODM shall:

(i) Notify the ODA case manager, as applicable, in writing of the authorized amount, scope and duration of PDN services and the PDN authorization number. The ODA case manager shall notify the PDN provider of the authorized amount, scope and duration of PDN services and the PDN authorization number. The PDN provider shall begin furnishing PDN services to the individual upon receipt of written PDN authorization and in accordance with all other requirements set forth in rule 5160-12-02 of the Administrative Code.

(ii) Inform the individual of PDN authorization specifying the authorized amount, scope and duration of PDN services.

(b) If the individual disagrees with the authorized amount, scope and/or duration of PDN services, the individual may request a hearing in accordance with division 5101:6 of the Administrative Code.

(c) If ODM cannot confirm, in accordance with rule 5160-12-02 of the Administrative Code, the individual is enrolled on an ODA administered waiver, and/or cannot confirm that the individual has a medical condition that requires PDN services that are medically necessary in accordance with rule 5160-1-01 of the Administrative Code, ODM shall:

(i) Deny the PDN authorization request and issue a denial notice and hearing rights to the individual in accordance with division 5101:6 of the Administrative Code.

(ii) Notify the ODA case manager in writing of the denial of the PDN authorization request. The ODA case manager shall notify the PDN provider in writing of the denial.

(3) The provider shall notify ODM and the ODA case manager in writing using the ODM 02374 when there is any change in the individual's condition that the provider believes may warrant a change in the amount, scope or duration of PDN services.

(4) The ODA case manager shall notify ODM in writing using the ODM 02374 when there is a change in the individual's level of care.

(D) The procedures set forth in this paragraph must be followed when obtaining PDN approval for an individual enrolled on a HCBS waiver administered by the Ohio department of developmental disabilities (DODD). The period for which PDN approval applies shall not exceed three hundred sixty-five days.

RESCINDED- NOT FOR FILING

(1) The individual, or PDN provider shall request that the county board services and support administrator (SSA) submit a referral for PDN services to the designee at DODD along with any additional supporting documentation requested by DODD. The county board SSA shall assist the individual in securing a potential PDN service provider.

(2) DODD shall determine if, in accordance with rule 5160-12-02 of the Administrative Code, the individual has a medical condition that requires PDN services which are medically necessary, as set forth in rule 5160-1-01 of the Administrative Code.

(a) If DODD determines the individual has a medical condition that requires PDN services which are medically necessary, DODD shall notify the county board SSA in writing of the authorized amount, scope and duration of PDN services.

(i) County board SSA shall notify the PDN provider of the authorized amount, scope and duration of PDN services. The PDN provider shall begin furnishing PDN services to the individual upon receipt of written PDN approval and in accordance with all other requirements set forth in rule 5160-12-02 of the Administrative Code.

(ii) County board SSA shall inform the individual of PDN authorization specifying the authorized amount, scope and duration of PDN services.

(b) If the individual disagrees with the authorized amount, scope and/or duration of PDN services, the individual may request a hearing in accordance with division 5101:6 of the Administrative Code.

(c) If DODD determines the individual does not have a medical condition that requires PDN services and/or the services are not medically necessary as set forth in rule 5160-1-01 of the Administrative Code, DODD:

(i) Shall deny the PDN service request, and issue a denial notice and hearing rights to the individual in accordance with division 5101:6 of the Administrative Code, and

(ii) Shall notify the county board SSA and the PDN provider of the denial of the PDN authorization request.

(E) PDN services shall be approved for individuals enrolled on an ODM administered HCBS waiver as a result of the in-person assessment or reassessment conducted by ODM or its designee in accordance with rule 5160-46-02 of the Administrative Code, or the reassessment conducted in accordance with rule 5160-50-02 of the Administrative Code. As set forth in rule 5160-12-02 of the Administrative Code, PDN services must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code.

(1) The case manager shall assist the individual in securing a PDN service provider.

(2) If PDN services are approved, ODM or its designee shall:

(a) Record the amount, scope and duration of approved PDN services on the all services plan.

(b) Notify the provider, in writing, of the amount, scope and duration of approved PDN services.

(c) Inform the individual of PDN service approval in writing after conducting the assessment or reassessment, and provide a written notice to the individual specifying the approved amount, scope and duration of PDN services.

(3) If the individual disagrees with the authorized amount, scope and/or duration of PDN services, the individual may request a hearing in accordance with division 5101:6 of the Administrative Code.

(4) If PDN services are denied, ODM or its designee shall issue a denial notice and hearing rights to the individual in accordance with division 5101:6 of the Administrative Code.

(5) Requests for a change in the amount, scope and/or duration of authorized PDN services shall be submitted to ODM or its designee. ODM or its designee shall conduct an in-person reassessment and/or perform a desk review to evaluate the request.

(F) Additional PDN services beyond what ODM or its designee has authorized may be provided to an individual in an emergency when the provider has an existing PDN authorization to provide PDN services to that individual. For the purposes of this rule, emergency services are provided outside of normal state of Ohio office hours when prior authorization cannot be obtained.

(1) PDN services may be delivered in an emergency and a new PDN authorization obtained after the delivery of services. The PDN services must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code, and the services must be necessary to protect the health and welfare of the individual.

(2) The provider shall notify ODM, or the ODA case manager, as applicable, in writing using the ODM 02374, or the county board SSA for individuals enrolled on a DODD administered waiver when emergency PDN services are delivered. Notification shall be immediate, or no later than the first business day following the emergency provision of PDN services.

(G) The provider shall maintain all written records related to the provision of PDN service and its authorization for a period of six years following receipt of the request or until an initiated audit is resolved, whichever is longer.

DRAFT - NOT FOR FILING

5160-12-02.3 Private duty nursing: procedures for service authorization.

(A) The process of submitting a request for PDN or a change in the amount, scope, or duration of authorized PDN services is dependent on the individual's home and community-based services (HCBS) waiver enrollment status and service payer, as follows:

(1) For individuals in fee for service, who are not enrolled on an HCBS waiver, a request for PDN is submitted to ODM using the ODM 02374, "Private Duty Nursing (PDN) Services Request", along with supporting documentation requested by ODM.

(2) For individuals enrolled on the Ohio department of aging (ODA) preadmission screening system providing options and resources today (PASSPORT) waiver, a request for PDN is submitted to ODM using the ODM 02374, "Private Duty Nursing (PDN) Services Request", along with supporting documentation requested by ODM.

(3) For individuals enrolled on an Ohio department of developmental disabilities (DODD) HCBS waiver, they will need to request a referral be made through their county board of developmental disabilities services and support administrator (SSA), along with supporting documentation requested by DODD.

(4) For individual enrolled on an Ohio home care waiver, they will request a referral be made through their waiver case manager, along with any additional supporting documentation requested by ODM.

(5) For individuals enrolled in a MCO, the provider will follow submission procedures designated by the individual's MCO.

(B) ODM or its designee will conduct an in-person assessment or perform a desk review to determine if the individual has needs that necessitate PDN services or PDN services are in accordance with rule 5160-12-02 of the Administrative Code. The assessor will notify the referral source or individual in writing of the outcome of the eligibility determination.

(1) Service approval will include authorized amount, scope, and duration of PDN services and the PDN authorization number.

(2) Service denial will include a denial notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(C) If the individual disagrees with the authorized amount, scope or duration of PDN services, the individual may request a hearing in accordance with division 5101:6 of the Administrative Code.

(D) Additional PDN services beyond what ODM or its designee has authorized may be provided to an individual in an emergency when the provider has an existing PDN authorization to provide PDN services to that individual. For the purposes of this rule, emergency services are provided outside of normal state of Ohio office hours when prior authorization cannot be obtained.

(1) PDN services may be delivered in an emergency and a new PDN authorization obtained after the delivery of services. The PDN services have to be medically necessary in accordance with rule 5160-1-01 of the Administrative Code, and the services need to be necessary to protect the health and welfare of the individual. If the individual disagrees with the authorized amount, scope and/or duration of PDN

services, the individual may request a hearing in accordance with division 5101:6 of the Administrative Code.

(2) The provider will notify ODM or its designee when emergency PDN services are delivered. Notification is immediate when possible, or no later than the first business day following the emergency provision of PDN services.

RESCINDED- NOT FOR FILING

5160-12-03 Medicare certified home health agencies: qualifications and requirements.

(A) A medicare certified home health agency (MCHHA) that meets the requirements of this rule is eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code.

(B) MCHHAs are required to:

(1) Be certified for medicare participation by the Ohio department of health (ODH) in accordance with Chapter 3701-60 of the Administrative Code.

(2) Meet the conditions of participation in accordance with 42 C.F.R. Part 484 (October 1, 2014).

(3) Implement policy components for home health and private duty nursing (PDN) as specified in the "medicare benefit policy manual, chapter seven: home health services" (January 14, 2014) for the following sections:

(a) Section 20 "Conditions to be met for coverage of home health services";

(b) Secton 30.2"Services are provided under a plan of care established by and approved by a physician" to Section 30.3 "under the care of a physician"; and

(c) Section 40 "Covered services under a qualifying home health plan of care" to Section 50.3 "medical social services".

(4) Comply with all applicable requirements for medicaid providers in Chapter 5160-1 of the Administrative Code.

(5) Comply with all federal, state and local laws and regulations as applicable.

(6) Have back up staff available to provide services when the MCHHA's regularly scheduled staff cannot or do not meet their obligation to provide services.

(7) Submit written notification to the individual at least thirty days prior to the last date of service when terminating a service unless:

(a) The individual's treating physician has discontinued home health services;

(b) The treating physician has been notified that goals have been met;

(c) The individual no longer resides at their known place of residence or their whereabouts are unknown;

(d) The individual or another person has harmed or threatened to harm staff of the MCHHA;

(e) The individual requested that services be terminated; or

(f) The individual has been enrolled in a medicaid managed care plan (MCP).

(8) Contact the individual's medicaid MCP when applicable to request prior authorization for home health and PDN services.

(9) Maintain documentation on all aspects of services provided in accordance with this chapter. All documentation must be complete prior to billing for services provided in accordance with this chapter

and is subject to monitoring by ODM. This includes but is not limited to:

(a) Clinical records, including all signed orders.

(b) Time keeping records that indicate the date and time span of the services provided during each visit, and the type of service provided.

(10) Obtain the completed and signed ODM 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 7/2014), which certifies the medical necessity for services in accordance with rule 5160-12-01 or rule 5160-12-02 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-12-03 Home Health Service Providers

(A) Home health services are provided by medicare certified home health agencies (MCHHA). MCHHAs are mandated to:

(1) Be certified for medicare participation by the Ohio department of health (ODH) in accordance with Chapter 3701-60 of the Administrative Code.

(2) Meet the conditions of participation in accordance with 42 C.F.R. Part 484 (October 1, 2014).

(B) Providers of home health services need to submit written notification to the individual at least thirty days prior to the last date of service when terminating a service unless:

(1) The individual's treating physician has discontinued home health services.

(2) The treating physician has been notified that goals have been met;

(3) The individual no longer resides at their known place of residence or their whereabouts are unknown;

(4) The individual or another person has harmed or threatened to harm staff of the MCHHA;

(5) The individual has had a change in payor

(C) Providers of home health services will maintain documentation on all aspects of services provided in accordance with this chapter. All documentation should be complete prior to billing for services provided and is subject to monitoring by ODM in accordance with rule 5160-1-27 of the Administrative Code. This includes:

(1) Clinical records, including all signed orders, and

(2) Time keeping records that indicate the date and time span of the services provided during each visit, and the type of services provided.

(D) Providers of home health services should notify the individual when the MCHHA's regularly scheduled staff cannot or do not meet their obligation to provide services.

(E) Providers of home health services will contact the individual's medicaid managed care organization MCO), when applicable, to request prior authorization for home health services.

(F) Providers of home health services need to obtain the completed and signed ODM 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services", which certifies the medical necessity for services in accordance with rule 5160-12-01 Administrative Code.

(G) If the individual is enrolled in a home and community-based services (HCBS) waiver, then services will be coordinated with the waiver administrator and documented in their person-centered care plan.

RESCINDED- NOT FOR FILING

5160-12-03.1 Non-agency nurses and otherwise-accredited agencies: qualifications and requirements.

(A) "Non-agency nurses" and "otherwise-accredited agencies" who meet the qualifications and requirements of this rule can provide private duty nursing (PDN) in accordance with rule 5160-12-02 of the Administrative Code.

(B) A "non-agency nurse" that meets the requirements in accordance with this rule is eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code. A non-agency nurse is required to:

(1) Be a registered nurse or licensed practical nurse at the direction of a registered nurse practicing within the scope of his or her nursing license pursuant to Chapter 4723. of the Revised Code as an independent provider.

(2) Comply with the requirements of a medicare certified home health agency in accordance to rule 5160-12-03 of the Administrative Code except for paragraphs (A), (B)(1) and (B)(6) of rule 5160-12-03 of the Administrative Code.

(3) Not be the parent, step-parent, foster parent or legal guardian of an individual who is under eighteen years of age, or the individual's spouse.

(4) Meet all conditions of participation in paragraphs (C) and (D) of rule 5160-45-10 of the Administrative Code.

(5) Comply with all federal, state and local laws and regulations as applicable.

(C) "Otherwise-accredited agency" means 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, and that has executed a medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code. The accreditation shall be granted by a national accreditation organization approved by the centers for medicare and medicaid services (CMS), which may include but is not limited to, one of the following: the accreditation commission for health care (ACHC), the community health accreditation program (CHAP) and the joint commission.

(D) Providers of PDN services who are also providers of waiver services to an individual enrolled on a home and community based services (HCBS) waiver must comply with all applicable requirements including those set forth by the HCBS waiver rule(s).

DRAFT - NOT FOR FILING

5160-12-03.1 Private Duty Nursing Service Providers

(A) Medicare certified home health agencies" (MCHHAs), "non-agency nurses," and "otherwise-accredited agencies" who meet the qualifications and conditions of this rule can provide private duty nursing (PDN) in accordance with rule 5160-12-02 of the Administrative Code

(B) MCCHAs will:

(1) Be certified for medicare participation by the Ohio department of health (ODH) in accordance with Chapter 3701-60 of the Administrative Code.

(2) Meet the conditions of participation in accordance with 42 C.F.R. Part 484 (October 1, 2024).

(C) A "non-agency nurse" that meets the requirements in accordance with this rule is eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code. A non-agency nurse is mandated to:

(1) Be a registered nurse or licensed practical nurse at the direction of a registered nurse practicing within the scope of his or her nursing license pursuant to Chapter 4723. of the Revised Code as an independent provider.

(2) Not be the parent, step-parent, foster parent, legal guardian of an individual who is under eighteen years of age, or the individual's spouse.

(3) Meet all conditions of participation in paragraphs (B), (C) and (D) of rule 5160-44-31 of the Administrative Code.

(D) Otherwise-accredited agency" means 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, and that has executed a medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code. The accreditation will be granted by a national accreditation organization approved by the centers for medicare and medicaid services (CMS), which includes, the accreditation commission for health care (ACHC), the community health accreditation program (CHAP), and the joint commission.

(E) Providers of PDN services who are also providers of waiver services to an individual enrolled on a home and community based services (HCBS) waiver should comply with all applicable conditions. Services will also be coordinated with the waiver administrator and documented in their person-centered services plan.

(F) Providers of private duty nursing services will maintain documentation on all aspects of services provided in accordance with this chapter. All documentation should be complete prior to billing for services provided and is subject to monitoring by ODM in accordance with rule 5160-1-27 of the Administrative Code. This includes:

(1) Clinical records, including all signed orders, and

(2) Time keeping records that indicate the date and time span of the services provided during each visit, and the type of services provided.

(G) Providers of PDN services will notify the individual when the regularly scheduled staff cannot or do not meet their obligation to provide services.