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):

Ohio Home Care Waiver Services

Rule Number(s): 5160-46-04 (new/rescind), 5160-46-09 (new), 5160-46-10 (new), & 5160-46-12 (new)
The rules included for informational purposes only: 5160-46-06 (amend) & 5160-46-11 (new)

Date of Submission for CSI Review: 04/22/2025

Public Comment Period End Date: 04/29/2025

Rule Type/Number of Rules:

New/4 rules — No Change/____ rules (FYR? ___)

Amended/0 rules (FYR? no) — Rescinded/1 rules (FYR? ___)

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.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 5160-46-04, entitled "Ohio home care waiver: definitions of covered services and provider requirements and specifications" sets forth definitions and provider requirements and specifications for personal care aide services, adult day health center services, supplemental adaptive and assistive device services, and supplemental transportation services. The rule will be proposed due to the following:

   - Rename title to "Ohio home care waiver: personal care aide service"
   - Make the new rule specific to personal care aide services including the definition, provider requirements and specifications for the delivery of the service.
   - Completion of in-service continuing education hours reduced from twelve to eight within a twelve-month period for personal care aides employed at Medicare-certified and otherwise-accredited agencies
   - Amend language to align with section 4723.01 of the Revised Code that a licensed RN or a licensed LPN at the direction of a medical professional may provide supervision of personal care aides
   - Remove requirement that "At least twice per year, the RN will conduct RN assessment visits in-person. All other RN assessment service visits may be conducted via telehealth, unless the individual's needs necessitate an in-person visit. When the RN performs an RN assessment

visit, the RN will bill the state plan nursing assessment code set forth in appendix A to rule 5160-12-08 of the Administrative Code." This language is unnecessarily duplicative of the supervisory requirement stating a supervisor will “conduct a face-to-face individual home visit at least every sixty days while the personal care aide is present and providing care to evaluate the provision of personal care aide services and the individual’s satisfaction with care delivery and personal care aide performance.”

- Create new separate rules for each OHCW service found within 5160-46-04
- Remove restrictive language
- Statutory citation updates

Rule 5160-46-09, entitled “Ohio home care waiver: vehicle modification service” will set forth the service definition and provide requirements and specifications for vehicle modification. This will be a new rule.

- The current vehicle modification specification found within the supplemental adaptive and assistive device service in 5160-46-04. Vehicle modification will be its own separate service.

Rule 5160-46-10, entitled “Ohio home care waiver: supplemental transportation service” will set forth the service definition and provide requirements and specifications for supplemental transportation. This will be a new rule.

- The current supplemental transportation service language found within Rule 5160-46-04, entitled: “Ohio home care waiver: definitions of the covered services and provider requirements and specifications”.
- Addition of health and safety requirements that are not currently found in Rule 5160-46-04.

Rule 5160-46-12, entitled “Ohio home care waiver: adult day health center service” will set forth the service definition and provide requirements and specifications for adult day health center. This will be a new rule.

- The current adult day health center service language found within Rule 5160-46-04, entitled: “Ohio home care waiver: definitions of the covered services and provider requirements and specifications”.
- Updated commercial liability insurance coverage requirements will be in paragraph (D)(2) to align with the Ohio Department of Aging and the Ohio Department of Developmental Disabilities adult day center provider requirements.
- Addition of health and safety language requirements that are not currently found in Rule 5160-46-04.

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.**

5160-46-04, 5160-46-09, 5160-46-10, 5160-46-11, 5160-46-12

- Authorized By: 5166.02
- Amplifies: 5162.03, 5166.02

5160-46-09

- •Authorized By: 5166.02
- •Amplifies: 5162.03, 5164.02, 5166.02

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

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

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

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

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

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

ODM and its designees monitor providers to ensure compliance for the continued health and safety of individuals receiving services from ODM-certified providers. ODM will judge the proposed amended and new rules to be a success when ODM and its designees find few violations against providers during structural compliance reviews or investigations of alleged incidents.

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

No

Development of the Regulation

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

Throughout the development of the regulation, the Ohio Department of Medicaid (ODM) engaged partner agencies for their continuous review and feedback. ODM met with partners at the Ohio Department of Aging (ODA) and the Ohio Department of Developmental Disabilities (DODD) to discuss drafted regulations. ODM also met with the DODD and the Ohio Department of Public Safety on March 19, 2025 to discuss the adaptive mobility dealer licensure within the Ohio Revised Code 4517.01 as it relates to vehicle modification providers.

ODM also maintains active communication with stakeholders. Stakeholders consists of nursing facility-based waiver providers and participants. To engage a wide population of providers and participants, ODM also shared the draft proposed rules via email on March 7, 2025 with nearly 10,000 stakeholders including providers of vehicle modification and adult day health centers requesting their review and feedback.

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

Stakeholders are of critical importance in updating policy and practice, and in assuring the health and welfare of waiver participants. As a result of stakeholder feedback, the following changes were made to two rules to be proposed:

- OAC 5160-46-04:
  - Reduced hours of in-service continuing education requirements within a twelve-month period from twelve to eight hours for personal care aides employed by Medicare-certified and otherwise-accredited agencies.
  - Removed requirement that "At least twice per year, the RN will conduct RN assessment visits in-person. All other RN assessment service visits may be conducted via telehealth, unless the individual's needs necessitate an in-person visit. When the RN performs an RN assessment visit, the RN will bill the state plan nursing assessment code set forth in appendix A to rule 5160-12-08 of the Administrative Code." This language is unnecessarily duplicative of the supervisory requirement stating a supervisor will "conduct a face-to-face individual home visit at least every sixty days while the personal care aide is present and providing care to evaluate the provision of personal care aide services and the individual's satisfaction with care delivery and personal care aide performance."
- OAC 5160-46-09: Removed requirement that vehicle modification providers must be licensed as an adaptive mobility dealer in accordance with ORC 4517.01

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

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

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

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

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

The agency has an ongoing effort to align home and community-based services rules internally but also across other state agencies such as the Ohio Department of Aging and Ohio Department of Developmental Disabilities. As such, some rules may be duplicative as other agency policy areas amend rules as needed.

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.

ODM and its designees will provide outreach, education and technical assistance to providers and care coordination entities. Additionally, ODM will continue to monitor Ohio Home Care waiver providers for compliance.

Adverse Impact to Business

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

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

The following ODM-administered waiver providers will be impacted by the proposed rules: personal care aide, vehicle modification, supplemental transportation, and adult day health center

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.

OAC 5160-46-04 requires home health agencies to:

- Be Medicare-certified or otherwise accredited by a national accreditation body
  - Cost: New Medicare providers or ones that have not established a record in PECOS may be required to submit an initial application which in 2025 the fee is $730
  - Source: pecos.cms.hhs.gov
- Personal care aides must have a certificate of completion of either a competency evaluation program or training and competency evaluation program approved by the Ohio Department of Health, or the Medicare competency evaluation program for home health aides
  - Cost: Tuition fees for a home health aide certification programs are usually between $300 and $650

- Source: https://www.bizinsure.com/hha-certificate-class/
- Personal care aides must obtain and maintain first aid certification
  - Cost: First Aid/CPR/AED training costs range from $75-$126, and upon successful completion a 2-year certificate is issued
  - Source: https://www.redcross.org/take-a-class/first-aid
- Personal care aides must complete and maintain evidence of in-service continuing education
  - Cost: Continuing education class costs are dependent on training topics, the agency providing the training, etc. Some continuing education classes may be free such as trainings provided by PCG (ODM Contractor).
  - Source: https://ohiohcbs.pcgus.com/provider-training

❖ Reporting: The rule requires the provider to report to ODM or its designee, in writing, if they cannot perform IADL's.

OAC 5160-46-09 requires vehicle modification service providers to:

❖ Reporting: The rule requires the provider to submit to ODM or its designee a fixed cost proposal of the vehicle modification including documentation from an automotive service excellence-certified professional the vehicle is in good operating condition, written statement of service warranty and guarantee that materials furnished, and modifications installed perform their intended function. Also, the provider must report that the modification was completed in accordance with applicable federal, state, and local laws, modification was tested and in proper working order, attest the individual was instructed on usage of modification, attest the modification was completed in accordance with proposal, and written confirmation from the individual the modification was completed to their satisfaction.

OAC 5160-46-10 requires supplemental transportation service providers to:

- Maintain collision/liability insurance for each vehicle and driver
  - Cost: ODM is unable to provide estimate costs due to many factors taken into consideration for insurance costs
- Obtain and exhibit evidence of a valid motor vehicle inspections from the Ohio Highway Patrol for all vehicles used to provide services
  - Cost: Annual bus safety inspections conducted by the Ohio highway patrol office are $100
  - Source: https://codes.ohio.gov/ohio-administrative-code/rule-4501-52-02
- Drivers must possess a valid driver's license
  - Cost: An Ohio operator driver license is $24.50 and is valid for four years
  - Source: https://www.bmv.ohio.gov/doc-fees.aspx
- Drivers must obtain and maintain completion of a course in first aid
  - Cost: First Aid/CPR/AED training costs range from $75-$126, and upon successful completion a 2-year certificate is issued
  - Source: Source: https://www.redcross.org/take-a-class/first-aid

OAC 5160-46-12 requires adult day health center service providers to:

- Maintain a minimum of one million dollars in commercial liability insurance, which includes coverage for individual losses due to theft or property damage
  - Cost: ODM is unable to provide estimate costs due to many factors taken into consideration for insurance costs. However, we believe many adult day health center providers already have this minimum of one million dollars in commercial liability insurance due to this being a requirement for adult day health centers certified through the Ohio Department of Aging (ODA) and Department of Developmental Disabilities.
  - Source: ODA- https://codes.ohio.gov/ohio-administrative-code/rule-173-39-02
    DODD- https://codes.ohio.gov/ohio-administrative-code/rule-5123-2-08
- Maintain an annual fire inspection completed by local or state fire marshal.
  - Cost: Ohio fire safety inspection fees are $100.
  - Source: https://codes.ohio.gov/assets/laws/administrative-code/rules/1301/7/1301$7-7-01_eff_1_5_19.pdf

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).*

The rules to be proposed improve readability and navigation to find specific Ohio home care waiver services, with each service now having its own rule.

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

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

Regulatory Flexibility

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

These rules treat all providers the same, regardless of their size.

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

regulation?

Whenever possible, ODM or its designee will treat administrative violations that do not involve health and safety as opportunities for improvement through warning notices and solicitation of corrective action.

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

ODM and its designee are available to help providers of all sizes with their questions. Providers may contact the ODM provider hotline at 1-800-686-1516.

DRAFT - NOT FOR FILING

5160-46-04 Ohio home care waiver: personal care aide service.

This rule sets forth the definition of personal care aide services as well as the provider requirements and specifications for the delivery of the service. Providers are also subject to the conditions of participation set forth in rule 5160-44-31 of the Administrative Code. Services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) "Personal care aide services" are defined as services provided pursuant to the person-centered services plan (PCSP) that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. If the provider cannot perform IADLs, the provider will notify the Ohio department of medicaid (ODM) or its designee, in writing, of the service limitations before inclusion on the individual's PCSP. Personal care aide services include:

(1) 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 of intake and output;

(2) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors, and waste disposal;

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

(4) Accompanying or transporting the individual to Ohio home care waiver services, medical appointments, other community services, and running errands on behalf of that individual.

(B) Personal care aide services do not include tasks performed, or services provided as part of the home maintenance and chore services set forth in rule 5160-44-12 of the Administrative Code.

(C) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the PCSP.

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

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

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

(3) Opening the container for an individual who is physically unable to open the container;

(4) Assisting an individual who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and

(5) Assisting an individual who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it, by placing the dose in another container and placing that container to the mouth of the individual.

(E) Personal care aide services will be delivered by one of the following:

(1) An employee of a medicare-certified, or otherwise-accredited home health agency; or

(2) A non-agency personal care aide.

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

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

(2) Comply with the additional applicable provider-specific criteria as specified in paragraphs (G) or (H) of this rule.

(G) Medicare-certified and otherwise-accredited agencies will ensure that personal care aides meet the following criteria:

(1) Before commencing service delivery, the personal care aide will:

(a) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.80 (as in effect on October 1, 2024), and

(b) Obtain and maintain first aid certification from a program that may be 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.

(2) Maintain evidence of the completion of eight hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education will be initiated immediately and will be completed annually thereafter.

(3) Receive supervision from a licensed RN or a licensed LPN at the direction of a medical professional in accordance with section 4723.01 of the Revised Code. The supervising RN or LPN will:

(a) Conduct a face-to-face individual home visit at least every sixty days while the personal care aide is present and providing care to evaluate the provision of personal care aide services and the individual's satisfaction with care delivery and personal care aide's performance.

(i) Document each visit in the individual's record.

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

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

(5) This rule sets the minimum standards for Ohio home care waiver agency personal care aide providers. Medicare-certified and otherwise-accredited agencies remain responsible for ensuring the requirements of applicable medicare certification or other accreditation standards are met.

(H) Non-agency personal care aides will meet the following criteria:

(1) Before commencing service delivery personal care aides will have:

(a) Obtained a certificate of completion within the last twenty-four months for either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.80 (as in effect on October 1, 2024); or other equivalent training program. The program will include training in the following areas:

(i) Personal care aide services as defined in paragraph (A) of this rule;

(ii) Basic home safety; and

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

(b) Obtained and maintained 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.

(2) Complete six hours of in-service continuing education annually that will occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to, health and welfare of the individual, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.

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

(4) Comply with ODM monitoring activities in accordance with rule 5160-45-06 of the Administrative Code.

(I) All personal care aide providers will maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited agencies, will maintain the clinical records at their place of business. Non-agency personal care aides will maintain the clinical records at their place of business and maintain a copy of the records in the individual's residence. For the purposes of this rule, the place of business will be a location other than the individual's residence. At a minimum, the clinical record will contain:

(1) Identifying information of the individual including but not limited to name, address, age, date of birth, phone number(s) and health insurance identification numbers.

(2) The medical history of the individual.

(3) The name of individual's treating physician.

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

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

(6) A copy of any advance directives including, but not limited to, a do not resuscitate (DNR) order or

medical power of attorney, if they exist.

(7) Documentation of authorized tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and individual or the individual's authorized representative, verifying the service delivery upon completion of the service delivery. The individual or the individual's authorized representative's signature of choice will be documented on the individual's PCSP and will include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

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

(9) A discharge summary, signed and dated by the departing non-agency personal care aide or the RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the individual, or when the individual no longer needs personal care aide services.

(a) The summary should include documentation regarding progress made toward achievement of goals as specified on the individual's PCSP and indicate any recommended follow-ups or referrals.

(b) The discharge summary is not needed in the event the individual dies.

(J) Personal care aide services will be provided in accordance with the individual's PCSP.

DRAFT - NOT FOR FILING

TO BE RESCINDED

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

This rule sets forth definitions of some services covered by the Ohio home care waiver. This rule also sets forth the provider requirements and specifications for the delivery of those Ohio home care waiver services. Providers are also subject to the conditions of participation set forth in rule 5160-44-31 of the Administrative Code. Services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) Personal care aide services.

(1) "Personal care aide services" are defined as services provided pursuant to the person-centered services plan (PCSP) that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. If the provider cannot perform IADLs, the provider will notify ODM or its designee, in writing, of the service limitations before inclusion on the individual's PCSP. Personal care aide services include:

(a) Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;

(b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors and waste disposal;

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

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

(2) Personal care aide services do not include tasks performed, or services provided as part of the home maintenance and chore services set forth in rule 5160-44-12 of the Administrative Code.

(3) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the PCSP.

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

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

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

(c) Opening the container for an individual who is physically unable to open the container;

(d) Assisting an individual who is physically-impaired, but mentally alert, in removing oral or topical

medication from the container and in taking or applying the medication; and

(e) Assisting an individual who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the individual.

(5) Personal care aide services will be delivered by one of the following:

(a) An employee of a medicare-certified, or otherwise-accredited home health agency; or

(b) A non-agency personal care aide.

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

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

(b) Comply with the additional applicable provider-specific requirements as specified in paragraph (A)(7) or (A)(8) of this rule.

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

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

(i) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.80 (as in effect on October 1, 2023), and

(ii) Obtain and maintain first aid certification from a program that may be from a class that is not solely internet-based, and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

(b) Maintain evidence of the completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education will be initiated immediately, and will be completed annually thereafter.

(c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN, at the direction of an RN in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, will:

(i) Conduct a face-to-face individual home visit explaining the expected activities of the personal care aide, and identifying the individual's personal care aide services to be provided.

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

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

(d) At least twice per year, the RN will conduct RN assessment visits in-person. All other RN assessment service visits may be conducted via telehealth, unless the individual's needs necessitate an in-person visit. When the RN performs an RN assessment visit, the RN will bill the state plan nursing assessment code set forth in appendix A to rule 5160-12-08 of the Administrative Code.

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

(8) Non-agency personal care aides will meet the following requirements:

(a) Before commencing service delivery personal care aides will have:

(i) Obtained a certificate of completion within the last twenty-four months for either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.80 (as in effect on October 1, 2023); or other equivalent training program. The program will include training in the following areas:

(a) Personal care aide services as defined in paragraph (A)(1) of this rule;

(b) Basic home safety; and

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

(ii) Obtained and maintain first aid certification from a class that 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 six hours of in-service continuing education annually that will occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to, health and welfare of the individual, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.

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

(d) Comply with ODM monitoring requirements in accordance with rule 5160-45-06 of the Administrative Code.

(9) All personal care aide providers will maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited agencies, will maintain the clinical records at their place of business. Non-agency personal care aides will maintain the clinical records at their place of business, and maintain a copy in the individual's residence. For the purposes of this rule, the place of business will be a location other than the individual's residence. At a minimum, the clinical record will contain:

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

(b) The medical history of the individual.

(c) The name of individual's treating physician.

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

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

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

(g) Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and individual or the individual's authorized representative, verifying the service delivery upon completion of service delivery. The individual or the individual's authorized representative's signature of choice will be documented on the individual's PCSP, and will include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

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

(i) A discharge summary, signed and dated by the departing non-agency personal care aide or the RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the individual, or when the individual no longer needs personal care aide services.

(i) The summary should include documentation regarding progress made toward achievement of goals as specified on the individual's PCSP and indicate any recommended follow-ups or referrals.

(ii) The discharge summary is not required in the event the individual dies.

(B) Adult day health center services.

(1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to individuals who are age eighteen or older. A qualifying adult day health center will be a freestanding building or a space within another building that will not be used for other purposes during the provision of ADHCS.

(a) An adult day health center will provide:

(i) Waiver nursing services as set forth in rule 5160-44-22 of the Administrative Code, or personal care aide services as set forth in paragraph (A)(1) of this rule;

(ii) Recreational and educational activities; and

(iii) At least one meal, but no more than two meals, per day that meet the individual's dietary requirements.

(b) An adult day health center may also provide:

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

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

(c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided in a day.

(d) All of the services set forth in paragraphs (B)(1)(a) and (B)(1)(b) of this rule and delivered by an adult day health center will not be reimbursed as separate services.

(2) ADHCS do not include services performed in excess of what is approved pursuant to, and specified on, the individual's PCSP.

(3) In order to be a provider and submit a claim for reimbursement, providers of ADHCS will operate the adult day health center in compliance with all federal, state and local laws, rules and regulations.

(4) All providers of ADHCS will:

(a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, 2023).

(b) Provide for replacement coverage of a loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps an individual takes to file a liability claim. Upon request, verification of coverage will be provided to ODM or its designee.

(c) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training every twelve months.

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

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

(f) At all times, maintain a one to six ratio of paid direct care staff to individuals.

(5) Providers of ADHCS will maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record will contain the following:

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

(b) The medical history of the individual.

(c) The name of the individual's treating physician.

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

(e) A copy of any advance directive including, but not limited to, DNR order or medical power of attorney, if they exist.

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

(g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the individual's arrival and departure times. The use of technology-based systems may be used in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the individual no longer needs ADHCS. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(i) Documentation of the information set forth in rule 5160-44-22 of the Administrative Code when the individual is provided waiver nursing and/or skilled therapy services.

(C) Supplemental adaptive and assistive device services.

(1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. All supplemental adaptive and assistive device services will be prior-approved by ODM or its designee. ODM or its designee will only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

(a) Reimbursement for medical equipment, supplies and vehicle modifications will not exceed a combined total of ten thousand dollars within a calendar year per individual.

(b) ODM or its designee will not approve the same type of medical equipment, supplies and devices for the same individual during the same calendar year, unless there is a documented need for ongoing medical equipment, supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.

(c) ODM or its designee will not approve the same type of vehicle modification for the same individual within the same three-year period, unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

(d) Supplemental adaptive and assistive device services do not include:

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

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

(iii) Equipment, supplies or services furnished in excess of what is approved in the individual's PCSP;

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

(v) Activities described in paragraph (C)(2)(c) of this rule.

(2) Vehicle modifications.

(a) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same individual. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.

(b) Before the authorization of a vehicle modification, the individual and, if applicable, any other person(s) who will operate the vehicle will provide ODM or its designee with documentation of:

(i) A valid driver's license, with appropriate restrictions, and if requested, evidence of the successful completion of driver training from a qualified driver rehabilitation specialist, or a written statement from a qualified driver rehabilitation specialist attesting to the driving ability and competency of the individual and/or other person(s) operating the vehicle;

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

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

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

(c) Vehicle modifications do not include:

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

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

(iii) Permanent modification of leased vehicles;

(iv) Vehicle inspection costs;

(v) Vehicle insurance costs;

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

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

(3) In order to be a provider and submit a claim for supplemental adaptive and assistive device services, the provider will:

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

(b) Ensure the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.

(4) Providers of supplemental adaptive and assistive device services will maintain a clinical record for each individual they serve in a manner that protects the confidentiality of these records. At a minimum, the clinical record will include:

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

(b) The name of the individual's treating physician.

(c) A copy of the initial and all subsequent PCSP.

(d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. The use of technology-based systems may be used in collecting and maintaining the documentation required by this paragraph.

(5) The authorization of supplemental adaptive and assistive device services may be combined with other waiver services to meet the assessed needs of the individuals. In such instances, individual waiver service limits as described in paragraph (C)(1)(a) of this rule still apply.

(D) Supplemental transportation services.

(1) "Supplemental transportation services" are transportation services that are not available through any other resource that enable an individual to access waiver services and other community resources specified on the individual's PCSP. Supplemental transportation services include, but are not limited to assistance in transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.

(2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) Agency supplemental transportation service providers will:

(a) Maintain a current list of drivers.

(b) Ensure all drivers providing supplemental transportation services are age eighteen or older.

(c) Maintain a copy of the valid driver's license for each driver.

(d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services.

(e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.

(f) Obtain and maintain a certificate of completion of a course in first aid for each driver used to provide supplemental transportation services that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course, and certification that education was received from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.

(g) Ensure drivers are not the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.

(h) Ensure drivers are not the individual's foster caregivers.

(4) Non-agency supplemental transportation service providers will:

(a) Be age eighteen or older.

(b) Possess a valid driver's license.

(c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services.

(d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.

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

(f) Not be the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.

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

(5) All supplemental transportation service providers will maintain documentation that, at a minimum, includes a log identifying the individual transported, the date of service, pick-up point, destination point, mileage for each trip, and the signature of the individual receiving supplemental transportation services, or the individual's authorized representative. The individual's or authorized representative's signature of choice will be documented on the individual's PCSP and will include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(E) OHCW covered services described in this rule will be provided in accordance with the individual's PCSP.

DRAFT - NOT FOR FILING

5160-46-10 Ohio home care waiver: supplemental transportation service.

This rule sets forth the definition of the supplemental transportation service as well as the provider requirements and specifications for the delivery of the service. Providers are also subject to the conditions of participation set forth in rule 5160-44-31 of the Administrative Code. Services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) "Supplemental transportation services" are transportation services that are not available through any other resources that enable an individual to access waiver services and other community resources specified on the individual's person-centered services plan (PCSP). Supplemental transportation services include but are not limited to assistance in transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.

(B) Supplemental transportation services do not include services, performed in excess of what is specified on the individual's person-centered services plan..

(C) Agency supplemental transportation service providers will:

(1) Maintain a current list of drivers.

(2) Ensure all drivers providing supplemental transportation services are age eighteen years or older.

(3) Maintain a copy of the valid driver's license for each driver.

(4) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services.

(5) 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.

(6) Obtain and maintain a certificate of completion of a course in first aid for each driver used to provide supplemental transportation services, that is not solely internet-based, that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course. Obtain certification that education was received from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.

(7) Ensure drivers are not the individual's foster caregiver or legally responsible family member as defined in rule 5160-45-01 of the Administrative Code.

(D) Non-agency supplemental transportation service providers will:

(1) Be age eighteen years or older.

(2) Possess a valid driver's license.

(3) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services.

(4) 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.

(5) Complete and maintain a certificate of completion of first aid from a class that is not solely internet-based,

that includes hands-on training by a certified first aid instructor, and a successful return demonstration of what was learned in the course. Obtain certification that education was received from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.

(6) Not be the individual's foster caregiver or legally responsible family member as defined in rule 5160-45-01 of the Administrative Code.

(E) All supplemental transportation service providers will:

(1) Maintain documentation that, at a minimum, includes a log identifying the individual transported, the date of service, pick-up point, destination point, mileage for each trip, and the signature of the individual receiving supplemental transportation services, or the individual's authorized representative. The individual's or authorized representative's signature of choice will be documented on the individual's PCSP and will include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

(2) Maintain a daily vehicle inspection log.

(3) Ensure a fire extinguisher is in each vehicle.

(4) Ensure potentially harmful items (such as lighters, sharp objects, etc.) are not left in vehicles.

(F) Supplemental transportation services will be provided in accordance with the individual's person-centered services plan.

DRAFT - NOT FOR FILING

5160-46-12 Ohio home care waiver: adult day health center service.

This rule sets forth the definition of the adult day health center service as well as the provider requirements and specifications for the delivery of the service. Providers are also subject to the conditions of participation set forth in rule 5160-44-31 of the Administrative Code. Services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to individuals who are age eighteen years or older. A qualifying adult day health center will be a freestanding building or a space within a building that is not a private residence and will not be used for other purposes during the provision of ADHCS.

(1) An adult day health center will provide:

(a) Waiver nursing services as set forth in rule 5160-44-22 of the Administrative Code or personal care aide services as set forth in rule 5160-46-04 of the Administrative Code;

(b) Recreational and educational activities; and

(c) At least one meal, but no more than two meals, per day that meet the individual's dietary needs.

(2) An adult day health center may also provide:

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

(b) Transportation of the individual to and from ADHCS. The ADHCS will ensure the following for all vehicles used for transportation:

(i) Maintain a daily vehicle inspection log.

(ii) Ensure a fire extinguisher is in each vehicle.

(iii) Ensure potentially harmful items (such as lighters, sharp objects, etc.) are not left in vehicles.

(3) ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided in a day.

(4) Services set forth in paragraphs (A)(1) and (A)(2) of this rule and delivered by an adult day health center will not be reimbursed as separate services.

(B) ADHCS do not include services performed in excess of what is approved pursuant to, and specified on, the individual's person-centered services plan (PCSP).

(C) Providers of ADHCS will operate the adult day health center in compliance with all federal, state, and local laws, rules, and regulations.

(D) All providers of ADHCS will:

(1) Comply with federal nondiscrimination regulations set forth in 45 C.F.R. part 80 (as in effect on October 1, 2024).

(2) Maintain a minimum of one million dollars in commercial liability insurance, which includes coverage for individual's losses due to theft or property damage and a written procedure identifying the steps an

individual takes to file a liability claim.

(3) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training every twelve months.

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

(5) Provide task-based instruction to direct care staff providing personal care aide services set forth in rule 5160-46-04 of the Administrative Code.

(6) At all times, maintain a minimum of a one to six ratio of paid direct care staff to individuals.

(7) Maintain working fire pull stations, fire extinguishers, smoke detectors, and carbon monoxide detectors on each level of the building. Smoke detectors will be tested at least monthly. Fire extinguishers will be serviced at least annually. The provider will maintain documentation which demonstrates testing and service was performed.

(8) Store all cleaning supplies, flammables, combustible, and other potentially hazardous chemicals in a secured location away from furnace, hot water heater, open flame, or food.

(9) Store potentially harmful items (such as tools, knives, etc.), medications, and medical waste disposable bins in a secured location inaccessible to individuals.

(10) Maintain sufficient environmental conditions to ensure the safety of individuals served, including electrical systems and wiring, heating and cooling systems, private well and sewer systems, and secured access to mechanical rooms. All damage to walls, ceilings, windows, doors, and screens which could present a health and safety risk should be promptly repaired.

(11) Maintain an emergency preparedness plan to be used in instances of weather-related (i.e. tornado), fire, and other emergencies. The plan includes a pre-determined tornado shelter area and evacuation site. Ad hoc emergency drills will be conducted at least quarterly, with no more than ninety days between drills. Documentation of the drills, the date, and type will be maintained by the provider. Emergency exits will be readily accessible and unobstructed.

(12) Maintain an elopement policy describing actions of staff responsibilities, including notification to law enforcement in the event of an elopement.

(13) Provide the individual with phone access in a private space.

(14) Maintain evidence of passing a fire inspection completed by the local or state fire marshal.

(a) New service providers as of July 1, 2025: upon application to become an ADHCS service provider.

(b) Current service providers as of July 1, 2025: no later than December 31, 2025 and at least annually, with no more than three hundred sixty-five days between inspections thereafter.

(15) Publicly display the building floor plan displaying the location of fire extinguishers and emergency exits.

(16) Maintain a smoking policy.

(17) Adhere to criteria set forth in paragraph (C) of rule 5160-46-10 of the Administrative Code when

providing transportation to individuals.

(E) Providers of ADHCS will maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record will contain the following:

(1) Identifying information for the individual including but not limited to name, address, age, date of birth, phone number(s), and health insurance identification numbers.

(2) The medical history of the individual.

(3) The name of the individual's treating physician.

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

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

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

(7) Documentation that clearly shows the date of ADHCS delivery, including authorized tasks performed or not performed, and the individual's arrival and departure times.

(8) A discharge summary, signed and dated by the departing ADHCS provider, at the point the individual no longer needs ADHCS. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(9) Documentation of the information set forth in rule 5160-44-22 of the Administrative Code when the individual is provided waiver nursing or skilled therapy services, or both.

(F) Adult day health center services will be provided in accordance with the individual's person-centered services plan.

DRAFT - NOT FOR FILING

5160-46-06 Ohio home care waiver program: covered services, reimbursement rates, and billing procedures.

(A) The following waiver services are covered by the Ohio home care waiver:

(1) Home delivered meals as described in rule 5160-44-11 of the Administrative Code

(2) Home maintenance and chores as described in rule 5160-44-12 of the Administrative Code

(3) Home modification as described in rule 5160-44-13 of the Administrative Code

(4) Community integration as described in rule 5160-44-14 of the Administrative Code

(5) Personal emergency response systems as described in rule 5160-44-16 of the Administrative Code

(6) Out-of-home respite as described in rule 5160-44-17 of the Administrative Code

(7) Waiver nursing as described in rule 5160-44-22 of the Administrative Code

(8) Community transition as described in rule 5160-44-26 of the Administrative Code

(9) Home care attendant as described in rule 5160-44-27 of the Administrative Code

(10) Structured family caregiving as described in rule 5160-44-33 of the Administrative Code

(11) Personal care aide as described in rule 5160-46-04 of the Administrative Code

(12) Vehicle modifications as described in rule 5160-46-09 of the Administrative Code

(13) Supplemental transportation as described in rule 5160-46-10 of the Administrative Code

(14) Supplemental adaptive and assistive devices as described in rule 5160-46-11 of the Administrative Code

(15) Adult day health center as described in rule 5160-46-12 of the Administrative Code

~~(A)~~ (B) Definitions of terms used for billing and calculating rates.

(1) "Base rate," as used in table A, column 3 of paragraph (C)~~(B)~~ of this rule, means the amount reimbursed by the Ohio department of medicaid (ODM) for the first thirty-five to sixty minutes of service delivered.

(2) "Bid rate," as used in table B, column 3 of paragraph (C)~~(B)~~ of this rule, means the per job bid rate negotiated between the provider and the individual's case manager.

(3) "Billing unit," as used in table B, column 3 of paragraph (C)~~(B)~~ of this rule, means a single fixed item, amount of time or measurement (e.g., a meal, a day, or mile, etc.).

(4) "Caretaker relative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(5) "Group rate," as used in paragraph (E)(1)~~(D)(1)~~ of this rule, means the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting.

(6) "Group setting" means a setting in which:

(a) A personal care aide service provider furnishes 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 ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(b) A waiver nursing service provider furnishes the same type of services to either:

(i) Two or three individuals at the same address. The services provided in the group setting can be either the same type of ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(ii) Two to four individuals at the same address if all of the individuals receiving ODM-administered waiver nursing services are:

(a) Medically fragile children, ~~and~~

(b) Siblings, and

(c) Residing together in the home of their caretaker relative. The services provided in the group setting will be ODM-administered waiver nursing services.

(c) A structured family caregiving service provider furnishes 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 ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(7) "Medicaid maximum rate" means the maximum amount that will be paid by medicaid for the service rendered.

(a) For the billing codes in table B of paragraph (C)~~(B)~~ of this rule, the medicaid maximum rate is set forth in column (4).

(b) For the billing codes in table A of paragraph (C)~~(B)~~ of this rule, the medicaid maximum rate is:

(i) The base rate as defined in paragraph (C)(1)~~(A)(1)~~ of this rule, or

(ii) The base rate as defined in paragraph (C)(1)~~(A)(1)~~ of this rule plus the unit rate as defined in paragraph (C)(7)~~(A) (7)~~ of this rule for each additional unit of service delivered, or

(iii) The unit rate as defined in paragraph (C)(7)(b)~~(A)(7)(b)~~ of this rule.

(8) "Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of the "Social Security Act," (42 U.S.C. 1382c(a)(2) or (3)) (as in effect on January 1, 2024).

(9) "Modifier," as used in paragraph (E)~~(D)~~ of this rule, means the additional two-alpha-numeric-digit billing codes that providers are required to use to provide additional information regarding service delivery.

(10) "Unit rate," as used in table A, column 4 of paragraph (C)~~(B)~~ of this rule, means the amount reimbursed by ODM for each fifteen minutes of service delivered when the visit is:

(a) Greater than sixty minutes in length.

(b) Less than or equal to thirty-four minutes in length. ODM will reimburse a maximum of only one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

~~(B)~~ (C) Billing code tables.

Table A

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Base rate	Unit rate
T1002	Waiver nursing services provided by an agency RN	$68.44	$9.25
T1002	Waiver nursing services provided by a non-agency RN	$56.26	$7.46
T1002	Waiver nursing services provided by a non-agency RN (overtime)	$84.39	$11.19
T1003	Waiver nursing services provided by an agency LPN	$58.72	$7.82
T1003	Waiver nursing services provided by a non-agency LPN	$48.00	$6.24
T1003	Waiver nursing services provided by a non-agency LPN (overtime)	$72.00	$9.36
T1019	Personal care aide services provided by an agency personal care aide	$28.96	$7.24
T1019	Personal care aide services provided by a non-agency personal care aide	$22.32	$5.58
T1019	Personal care aide services provided by a	$33.48	$8.37

DRAFT - NOT FOR FILING

Table A

	non-agency personal care aide (overtime)		

Table B

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Billing unit	Medicaid maximum rate
H0045	Out-of-home respite services	Per day	$199.82
S0215	Supplemental transportation services	Per mile	$0.48
S5101	Adult day health center services	Per half day	$53.11
S5102	Adult day health center services	Per day	$106.26
S5136	Structured family caregiving	Per day	$102.68
S5136	Structured family caregiving	Per half day	$51.34
S5160	Personal emergency response systems	Per installation and testing	$32.95
S5161	Personal emergency response systems	Per monthly fee	$32.95
S5165	Home modification services	Per item	Amount prior-authorized on the

Table B

			person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
S5170	Home delivered meal services - standard meal	Per meal	$8.80
S5170	Home delivered meal services - therapeutic or kosher meal	Per meal	$10.61
S5135	Community integration services	Per fifteen-minute unit	$3.93
T2038	Community transition services	Per job	$2,000 per waiver enrollment
T2039	Vehicle modification service	Per job	Amount prior-authorized on the person-centered services plan not

Table B

			to exceed $10,000 in a twelve-month calendar year
S5121	Home maintenance and chore services	Per job	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year

~~(C)~~ (D) The amount of reimbursement for a service will be the lesser of the provider's billed charge or the medicaid maximum rate.

~~(D)~~ (E) Required modifiers.

(1) The "HQ" modifier will be used when a provider submits a claim for billing code S5136, T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement as a group rate will be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.

(2) The "TU" modifier will be used when a provider submits a claim for billing code T1002, T1003 or T1019 and the entire claim is being billed as overtime.

(3) The "UA" modifier will be used when a provider submits a claim for billing code T1002, T1003 or T1019 and only a portion of the claim is being billed as overtime.

(4) The "UD" modifier will be used when a provider submits a claim for billing code S5136 for a half day of structured family caregiving.

(5) The "U1" modifier will be used when a provider submits a claim for billing code T1002 and the individual enrolled on the Ohio home care waiver is receiving infusion therapy.

(6) The "U2" modifier will be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(7) The "U3" modifier will be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.

(8) The "U4" modifier will be used when a provider submits a claim for billing code T1002, T1003 or T1019 for a single visit that was more than twelve hours in length but did not exceed sixteen hours.

(9) The "U6" modifier will be used when a provider submits a claim for billing code S5170 for a therapeutic or kosher home delivered meal.

~~(E)~~ (F) Claims will be submitted to, and reimbursement will be provided by, ODM in accordance with Chapter 5160-1 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-46-11 Ohio home care waiver: supplemental assistive and adaptive device service.

This rule sets forth the definition of the supplemental assistive and adaptive devices service and provider requirements and specifications for the delivery of the service. Providers are also subject to the conditions of participation set forth in rule 5160-44-31 of the Administrative Code. Services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

(A) "Supplemental adaptive and assistive device services" are medical equipment, supplies, and devices that not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. All supplemental adaptive and assistive device services will be prior-approved by the Ohio department of medicaid (ODM) or its designee. ODM or its designee will only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

(1) Reimbursement for medical equipment, supplies, and devices will not exceed a combined total of ten thousand dollars within a calendar year per individual. Supplemental adaptive and assistive device services in excess of the limit can be approved by ODM or its designee when there is a documented need.

(2) Supplemental adaptive and assistive device services 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 devices;

(c) Equipment, supplies, or services furnished in excess of what is approved in the individual's person-centered services plan (PCSP);

(d) Replacement of equipment or supplies, or repair of previously approved equipment or supplies that have been damaged as a result of perceived misuse, abuse, or negligence.

(B) In order to submit a claim for supplemental adaptive and assistive device services, the provider will:

(1) Ensure all manufacturer's rebates have been deducted before requesting reimbursement.

(2) Ensure the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.

(C) Providers of supplemental adaptive and assistive device services will maintain a clinical record for each individual they serve in a manner that protects confidentiality of these records. At a minimum, the clinical record will include:

(1) Identifying information of the individual including but not limited to name, address, age, date of birth, phone number(s), and health insurance identification numbers.

(2) The name of the individual's treating physician.

(3) A copy of the initial and all subsequent PCSP.

(4) Documentation verifying the date the supplemental adaptive and assistive device service was provided.

(D) The authorization of supplemental adaptive and assistive device services may be combined with other waiver services to meet the assessed needs of the individual. In such instances, the individual waiver service limits as described in paragraph (A)(1) of this rule still apply.

(E) Supplemental adaptive and assistive device services will be provided in accordance with the individual's person-centered services plan.