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| TO: | Becky Phillips, DODD |
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| FROM: | Anita Allen, OPRA |
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| DATE: | April 23, 2015 |
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| RE: | Comments - Ohio Department of Developmental Disabilities ("ODODD") Proposed Licensure Rules  |
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Thank you for the opportunity to provide input on the ODODD proposed Licensure Rules. The following comments reflect our internal analysis as well as comments submitted by our members.

**5123:2-3-01 Administration and Operation:**

(B)(13) The definition is unclear. Is this just for staff who work in the home? Only in an office? Both?

(B)(14), The definition of support staff has been changed from the current definition in 5123:2-3-01(H)(H) which referenced support staff "means those personnel employed by the residential facility who are not habilitation staff or professional staff, including but not limited to, secretaries, clerks, housekeepers, maintenance and laundry personnel." We need to make sure that we have not impacted who can be counted toward direct and indirect staff in an ICF or inadvertently impact cost reporting by changing this definition.

(C)(3), the Department has added a requirement that providers become compliant with the Americans with Disabilities Act. This is a new section and not otherwise required. Is the Department now requiring all licensed facilities to be ADA compliant? Please explain.

(D)(2) Although RAPBACK is positively perceived and used by many of our members, it is a new unfunded mandate that will increase both real (as in fees) and administrative costs. It is a system that needs to be monitored and maintained. As written, all current staff will have to be entered into the system and paid for. Some members utilize other services such as Webcheck, while others choose to run the required background checks on a schedule. Members who wish to utilize RAPBACK have been reporting problems with getting signed up through the portal. It does not appear that the system is completely functional yet. We would like for RAPBACK to remain voluntary. OPRA was very supportive of RAPBACK, through the planning, pilot and implementation phases. Our support was based in large part, in RAPBACK being voluntary and we made that clear.

(E)(2) Provision (f) contains a grandfather clause for Administrators. Does the grandfather clause apply to other requirements such as (g) (h) (i) (J)?

(E)(4) “*plan and efforts to employ a replacement within thirty days*” This is not a reasonable time frame. Most senior management positions take longer than 30 days to fill.

(F) There are new requirements relative to training. We are not sure from where they are derived and current licensure provisions have been changed. There is also a reference to the Provider Certification rule. How will the Provider Certification training requirements relate to licensed facilities? It is not clear.

It appears that the Department has taken out the currently existing section found in 5123:2‑3‑08(C)(3) where an employee is deemed to have met the requirements of 5123:2-3-08(C) under training requirements if they are scheduled for training and have completed the training within thirty (30) days. Has this been replaced somewhere?

(F)(d) This is a new requirement for ICF’s and eliminates potential staff hires in an already tight labor market.

(F)(i) Regarding staffing, the Department has made a change. Under current law, at least one staff on shift in a direct service position shall hold American Red Cross or equivalent certification in First Aid or Cardiopulmonary Resuscitation. The Department has changed this to a requirement for all staff. Please explain the change.

(F)(i) CPR/First Aid are not required in ICF’s where there are nurses on site 24/7. This presents an unreasonable hardship and is meaningless as only nurses are permitted to administer CPR. We request language that exempts ICF’s with 24/7 nursing services.

(G)(2) Supervisors who perform direct service in ICF’s do not need training in billing requirements. In addition, in many facilities they do very little in the way of managing individual’s funds. This requirement is unnecessary and does not take into account the various ways ICF’s are structured. There should be separate language for ICF’s.

(I)(4) We would like to suggest that background checks be done on volunteers who spend unsupervised time with individuals. The need for the check is not necessarily the number of hours involved, but in the tasks performed.

**5123:2-3-02 Physical Environment Standards:**

(C)(9) We request that the bedroom limit language in H.B. 64 be included in the rule.

(C)(11) Please define “adult”.

(D)(4) What if an individual chooses a futon and wishes to purchase one for his/her own use? Is this prohibited if it is a choice?

(D)(5) This is not practical for individuals who require total care and assistance with ADL’s. How will this standard be evaluated?

(E)(2) Has the fire drill schedule been intentionally removed?

**5123:2-3-03 Person Centered Planning:**

(C)(5) This provision governs service providers not guardians. How is this to be enforced? Who is responsible for enforcing? Who decides if the guardian’s decision is in “the best interest”? What if a determination is made by someone that the decision is not “in the best interest”? Providers cannot be held responsible for guardian decisions.

(E)(1) The rule makes no mention of federally mandated requirements in ICF’s. ICF’s must complete certain assessments, attempt medication reductions, and insure proper dietary care, for example. These requirements are in place to insure a minimum level of health and safety and cannot be over-ridden by guardian or individual decisions. We ask that the rule reflect federal requirements.

(C) We request that language that the individual’s choice of where to reside is noted and honored.

**5123:2-3-04 Provision of Services & Maintenance of Service Records**

(B)(1) Why does the definition include daytime and evening activities and not just say “activities”?

(C)(1)(c) While we understand the importance of this provision, we had questions on its meaning. Is the provider expected to know sign language if the individual uses it? What about individuals who are non-verbal or non-communicative? What is the standard for evaluation of this provision?

(E)(2)(c) This provision will be difficult to comply with. Should state 30 days, not 14.

(E) (2) (e) This is impossible for a provider to insure in H/PC transportation. The additional cost and administrative time is prohibitive. Are DSP’s expected it have vehicle inspections? By what entity? Who bears the cost?

(F)(1)(2) These 2 provisions could actually be in conflict with one another. Some food preferences might be in conflict with dietary restrictions. Language should be added that recognizes this fact.

(F)(3) This provision differs from the current rule and does not take into account the ability of an individual to actually prepare food. In addition, larger ICF’s have dietary departments that prepare meals according to specialized diets. Language should be included that recognizes these situations.

(H)(2) Currently, this provision provides an exception for community participation if it would be contraindicated. It has been changed to medically contra-indicated only. This is a very narrow exception and we do not recall any discussion about this. Community participation is sometimes behaviorally contra-indicated and language is needed that recognizes this.

(H)(3) This is not feasible in the way the active treatment rate is currently structured and should not apply to ICF’s. Under federal and state law, ICF’s are responsible for active treatment 24/7. Free choice of provider does not apply. As you know, many ICF residents were once served by other day service providers until the active treatment rate no longer covered the costs. The active treatment component of the rate has not changed and inflationary pressures have made the situation worse. There are very few day service providers willing to serve ICF residents for the funding available. This pressure resulted in many ICF agencies developing their own day programs. An increase in funding would open up more options.

(H)(4) This provision attempts to change the rules regarding day services and proximity to ICFs. First of all, this section refers to ‘day activities’ and there is no definition as to what that is. Will you use the definition that exists today in 5123:2-3-24? Please explain and define.

Second, the Department is broadening the definition of prohibited ‘day activities.’ Today, the ICF day array services cannot be provided 1) in the same building as the ICF, 2) in any residential facility, and c) within 200 feet of the building housing the ICF (5123:2-3-24). This change would broaden the prohibition to require that no day array services may be provided within 200 feet of any ICF, not just the licensed ICF building where the residents reside. Please explain. This will increase the cost of providing services for many ICF’s.

(I)(1)(f) Many liability insurance companies require MUI’s and UI’s be kept off of the actual residential site and in a separate office. This provision will conflict with liability insurance standards and might put liability coverage at risk.

(I)(2)(e) Regarding reconciliations and personal funds, will this rule apply to ICFs?

**5123:2-3-05 Admission, Termination and Transfer**

(B)(4) Regarding an emergency, the new language appears to require the operator to document attempts to provide, obtain, and/or coordinate the services necessary to ensure the health and safety of the resident, other residents and staff at the facility. The requirement for documentation of previous occurrences fails to take into account situations where an emergency may present itself but there were no previous occurrences which lead to the emergency situation. For instance, if someone has a stroke and they are no longer appropriate for the ICF, we assume that this would be an emergency situation. In sum, the definition of emergency appears to require documentation of previous events which may not be related to the emergency situation that presents itself.

(D)(4) Question – if an individual is admitted to a nursing home for 6 weeks for a specific medical intervention or therapy, is this considered an emergency and not subject to a 30 day notice?

**5123:2-3-06 Compliance Reviews, Issuance of Licenses, Adverse Actions**

(F)(1) Discusses three year terms only, but (G)(3) includes both one and three year terms.

Total deletion of term license requirements and Department survey tool and tool deleted as an attachment to the rule (now called compliance protocol) - Under Section 5123:2-3-06, the term license and licensure survey tool have been deleted and the new compliance reviews for licensed facilities will be conducted in accordance with a compliance protocol which takes the place of the licensure survey tool. Today, the license survey tool is promulgated as an attachment to the administrative rule. Accordingly, we believe that the new compliance protocol should remain part of the administrative rule process. The term license and licensure survey tool are currently found at Section 5123:2‑3‑03 and Appendix A of that same rule respectively, but are noticeably absent under the proposal. The Department is proposing to post the protocol on their web site but this is not meaningful due process. The creation of the web site compliance protocol and any subsequent changes will not be subject to notice, public input and due process as is required under the current administrative rule process governing the survey tool. We propose that the Department keep the tool/protocol as an appendix to the rule so that all stakeholders can have meaningful input and due process in the rulemaking process as is the case today with the survey tool.

(G) We had comments on the large jump in fees. Can you give your rationale?

(J)(1) This differs from current rule. If voluntarily surrendered, we would like to retain the licenses for possible future use in another location. We would like the voluntary language removed.

Provider appeal timelines shortened - Under Section 5123:2-3-06, the Department has reduced the time-frames for appeals of citations from a compliance review citation from 30 to 14 days. The current law under Section 5123:2-3-02(J)(6) requires that providers have 30 days to respond to the Department citations. The only reason that the Department gave for shortening the timelines associated with provider appeals was that the Department wants similar timelines for licensure appeals as are associated with supported living certification. We are opposed to shortening the current timelines associated with providers exercising their rights.

Provider appeal timelines shortened - Under Section 5123:2-3-06, the Department has shortened the time-lines for the provider to request reconsideration from 20 to 14 days. Why the change? The current requirements are found at Section 5123:2‑3‑02(Q)(5)(c). We ask that all current timelines for provider appeals and plans of correction be maintained.

Surveys will be called "compliance reviews" - In the proposed Section 5123:2-3-06, the Department has changed the terminology of licensure surveys to compliance reviews because the supported living standards are going to be the predominant standards. Again, we need to understand who will be conducting the compliance reviews as under the law, today, County Boards are prohibited from conducting compliance reviews of residential facilities under OAC 5123:2-2-04(C)(2). In discussions over the past several months, the Department has stated that it believes that County Boards may someday conduct the compliance reviews of residential facilities (both ICF and waiver homes). This is a strong departure from current practice. OPRA has concerns about County Boards taking on this function as this is a State function and is non-delegable. Further, several County Boards are license holders of ICF residential care licenses. This creates a conflict of interest. This needs much more discussion.

With regard to licensed HCBS facilities, currently, County Boards are prohibited from conducting any surveys or compliance reviews regarding licensed facilities. In fact, today it is clear that supported living standards do not apply to licensed facilities. The supported living rule regarding provider supported provider certification Section 5123:2-2-01(a) provides that "this rule does not apply to a person or government entity licensed as a residential facility under Section 5123.19 of the Revised Code." Thus, under today's standards, licensed facilities and certified supported living providers are governed by mutually exclusive laws. This will bring them together all under supported living standards.

Under the new definition section, the "Department" is defined as "the Ohio Department of Developmental Disabilities or its designee." As we mentioned, with regard to licensed facilities, only the Department may conduct surveys or compliance reviews and not any designee. The definition section opens this up and makes it unclear as to whether County Board will have a role with regard to licensed facilities. This is unacceptable with regard to any licensed facility – including group homes or ICFs.

Second, with regard to ICFs, it is troubling that the supported living standard will be the predominate standard. Many of the supported living standards are inapplicable to ICFs today as is evident from our comments. We ask that the Department reconsider these inconsistencies.

**5123:2-3-07 Immediate Removal of Residents**

(C)(1) Regarding the grounds for immediate removal, (C)(1) provides “upon receipt of an allegation that the physical or psychological health or safety of a resident of a residential facility is at risk, the county board shall determine if the situation is one of immediate danger.” Compared to current laws, the department is proposing to lower the standard from "danger" to "risk" and that would allow a county board to begin conducting their investigation regarding an allegation merely because they believe someone is at "risk." Currently, a county board can only conduct an investigation of an allegation that a resident is in danger. The new language would allow county boards to begin their investigation if the resident is at risk. At risk of what? The language is not clear and the standard is vague.

Division (C)(1)-(6) it appears that the department’s role is minimal and there is no duty on the department to conduct its own independent investigation. Rather, it appears that the department will rely solely on the county board to conduct the investigation and to inform the department about their opinion. This is not acceptable. There have been situations over the past year where county boards have conducted investigations which were not warranted at all. Providers were then required to spend thousands of dollars to try to undo an unwarranted county investigation. If the department is going to take the extreme step to remove someone from a facility, the department must have a role in seeing what is actually going on in the facility.

**5123:2-3-08 Development of Licensed Residential Beds**

General: There are numerous physical environment standards that should be moved to 5123:2-3-02 so they are all in one location.

1. The definition of “development” in Section (B)(5) has been revised to include “renovation” and remove “replacement.”
	* Replacement: Under the current 5123:2-3-26(B)(7) and (F)(4), a “replacement” of assigning licensed beds to a different licensee when a license is revoked, terminated or not renewed or voluntarily surrendered is permitted when the Department determined the beds are needed to provide services to the individuals who reside in the residential facility in which the beds are located. It appears that this option has been eliminated. What will happen to these beds when a license is revoked or a provider voluntarily goes out of business? Can they no longer sell the beds?
	* Renovation – As mentioned, this is new in the draft development rule. The definition of “renovation” in this new rule is what is currently found in 5123:2-3-02(B)(1). So this is not new. However, renovations are currently not subject to development approval by the Department. Currently, under 5123:2-3-02(G), a licensee is just required to notify the Department 30 days prior to its intent to begin a renovation, and the Department is to let the licensee know within 14 days if any new inspections and/or a licensure survey will be needed following the renovations. Although the development proposal process for renovations is separate for the process for modifications (see Section (H)) and mirrors the language from 5123:2-3-02(G), renovations will presumably now be subject to the Department’s discretion and approval as part of the broad development process and standards in the development rule. Further, since “renovation” is defined so broadly, providers could be burdened with submitting a development proposal for almost any renovation. This could be very cumbersome on providers and the Department in reviewing the proposals as well.
	* The new rule also includes “non-extensive” renovations under 5123:2-7-25 as part of the renovations requiring development approval at Section (H). 5123:2-7-25 is for non-extensive renovations for ICFs only, and this rule pertains to cost reporting, not Department approvals for the renovations. Moreover, no discussions were had with stakeholders regarding adding “renovations” to the development process and rule. We ask that the Department reconsider such a broad change.
2. Language regarding a facility’s ability to operate at its current “configuration” has been removed from (D)(2). Further, an applicant being permitted to proceed with development “at the capacity and configuration” for which it was approved was also removed. Why the Department removed such language is unclear. This should be clarified.
3. “Feasibility Requirements” have been added as Section (E). These “feasibility requirements” are just all of the construction and building requirements for licensure under 5123:2-3-10(B)(1)-(7), one fire safety requirement under 5123:2-3-11(C)(3) (requiring two means of exit), two (out of the 8) of the interior and exterior physical condition requirements under 5123:2-3-10(E)(2), and three other building requirements under 5123:2-3-10(H)-(J). Also added were space and usage licensure requirements and requirements for kitchen and dining and bathroom and laundry under 5123:2-3-10(D). So, although a large part of the physical environment requirements in 5123:2-3-10 are present in the draft rule, they are not all included. We ask that the Department explain why some are included and not others.
4. Also, why are the licensure requirements in Sections (E)-(F) included in the development rule? They are not referenced in the standards/what the Department should consider in reviewing development proposals in Section (G). How are they going to be used? Sanctions for violations of these licensure requirements (like suspension of admissions or licensure revocation) give providers Chapter 119 appeal rights under 5123:2-02, but the process to waive requirements under the development rule does not afford providers a Chapter 119 hearing. This is troubling and needs further explanation. 5123:2-3-08(J) provides that the provisions of this rule may be waived pursuant to 5123:2-3-10 (which is predominantly unchanged from the old 5123:2-3-15); this rule offers no due process rights whatsoever as the Director’s decision to grant or deny the waiver is final and not appealable. Please explain the change.
5. The bathroom and laundry requirement in (F)(4)(a) requires that the facility provide for toilet and bathing facilities at a minimum of 1:4. It cites 5123:2-3-10(D)(4) as the basis for this requirement. However, 5123:2-3-10(D)(4) does not require the 1:4 ratio, only that they be appropriate in number, size and design to meet the needs of the individuals and on each floor with bedrooms. Please explain why this is included.
6. The requirement in (E)(1) (first of the “Feasibility Requirements”) is new language not present in any current rule. It requires the interior and exterior of the facility to be configured in a manner that is (a) accessible to residents, (b) can accommodate the assessed needs and degree of ability of the residents, and (c) provides for service delivery that is age-appropriate. There are no definitions as to what these requirements mean. Please clarify.
7. Sections (I)(4)-(5) provides a person/government agency shall apply for a license (after obtaining development approval or placing a licensed bed on hold for future development) “in a manner prescribed by the department.” Language in the current rule provides that licensure can be applied for in accordance with 5123:2-3-02 (regarding licensure application). Why was this language changed? Is the Department going to change the licensure process? This gives the Department broad discretion and is an unknown that should be clarified.
8. As we have mentioned before, the Department’s “development proposal process” imposes Certificate of Need (CON)-like criteria to DD licensed beds.  This draft rule even further expands the Department’s authority to grant and deny development proposals by including renovations, even non-extensive renovations, in Section (H). Today, there is no CON requirement for residential beds, nor any statutory authority for the Department to impose a CON process to the development and renovation of licensed beds. The imposition of a rule that requires providers to meet a CON-like standard exceeds the Department’s statutory authority.  Accordingly, this would likely violate the first JCARR prong because it would exceed the scope of the Department’s statutory authority regarding licensed residential beds.

**5123:2-3-09 Standards for Evaluating Potential Receivers**

We have no comments on this rule.

**5123:2-3-10 Procedures to Waive Rule Requirements**

We have no comments on this rule.

**5123:2-2-07 Personal Funds of the Individual**

(E) Who is responsible to conduct the assessment? We would like to see the team be responsible as opposed to the SSA. We would also like to have a standardized assessment tool. We would also like language indicating how long an SSA, team, etc. could take to approve an expenditure request to insure things are taken care of in a timely manner. The language “shall be identified in the individual plan” is counter to Imagine and other person centered planning processes that have removed this type of language from ISP’s.

(G) Who decides what is covered by Medicaid or other payer source? Clarification is necessary because providers are sometimes told “it’s in your rate”, when in fact, it is not.

(H) This needs additional clarifying language. There are times when a provider covers costs (groceries, utilities, etc.) and is later reimbursed by the individual. Sometimes these situations are such that payment needs made immediately and cannot wait for prior authorization.

(J) When the individual has a payee, they are not permitted to establish their own account.

(L) This provision may be difficult to comply with. Sometimes guardians are non-responsive and do not comply with rules. We want to insure that providers are not held liable for guardian actions.

(N) This rule is silent on money management being billed as an H/PC service. Language needs included which specifies the differences between Representative Payee duties and H/PC money management and how each can be paid for. H/PC **can** pay for Rep Payee services, so other funding sources can be accessed for this, counter to the rule language. The Social Security Administration will not pay for services outside of their guidelines, however.

(P)(1)(b) The form 09405 can be accessed on ODM’s website. You might want to mention this. In addition, Social Security funds need to be returned to SSA.

Finally, we have requested on numerous occasions that this rule speak to a standardized audit process/protocol so that everyone is aware of the expectations and standards of practice. We again request inclusion of these provisions and do not consider this rule completed until such language added.

Thank you again for the opportunity to work with the Department on these important rules.