The Ohio Council
Of Behavioral Health & Family Services Providers

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Comments on Proposed Rule Amendments
OAC 5122-24-01 and 5122-25, 5122-26, 5122-27, and 5122-28
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The Ohio Council appreciates the opportunity to provide feedback on the Ohio Department of Mental Health & Addiction Services' (OhioMHAS) five-year rule review changes. The Ohio Council of Behavioral Health & Family Services Providers is a trade association representing 170 behavioral health organizations across the state of Ohio. The Ohio Council recognizes the importance of updating rules to comply with new state laws, as well as to advance quality in behavioral health services. However, there are several changes in this rule package that on face value appears to reverse long standing regulatory relief efforts and others that may have significant operational challenges that may negatively impact providers and further challenge efforts to attract and retain the community behavioral health workforce.

As we indicated during our meeting on February 28, 2024, we would like to schedule a meeting with OhioMHAS legal and policy leadership to discuss this rule package and understand the intent of some of these rule changes so we may work collaboratively to support implementation of needed or necessary changes. In the interest of collaboration, we are submitting these comments to seek clarification, raise concerns, and were possible have offered some initial recommendations to improve the language pending further discussions with OhioMHAS.

5122-25-02 – Certification procedure – initial application

1. Paragraph (B)(1)(e) outlines initial application requirements and requires submission of the applicant's budget. This is not a requirement of deemed providers under the current rule outlining certification procedures for deemed status providers (5122-25-04). Provider budget information routinely includes confidential financial information beyond public funding and presents a potential financial risk to organizations as this opens private businesses making confidential financial information a public record. Further, this is not required today for organizations with national accreditation, and we do not understand why OhioMHAS would expand business requirements in this environment.

   Recommendation: Remove (B)(1)(e), the requirement for an applicant to submit their budget.

2. Paragraph (D)(1)(a) introduces permissive language that implies OhioMHAS is rolling back regulatory relief and opens the door for duplicative onsite reviews for organizations that have received national accreditation. Specifically, (D)(1)(a) describes a process for OhioMHAS to conduct on-site reviews for any purpose and no longer recognizes national accreditation as meeting the state's requirements in accordance with the OhioMHAS national accreditation crosswalk that was recently published. An additional on-site review by OhioMHAS would constitute a duplication of the national accreditation onsite survey review, is an unnecessary expense of state resources, and an additional administrative cost of time and resources for providers that will be diverted from patient care. As currently written, this rule appears to eliminate the existing deemed status provisions and require both national

accreditation as well as the possibility of a separate state review process. The Ohio Council has supported national accreditation as a quality practice initiative for the last 20 years and advocated for requiring national accreditation for all OhioMHAS certified providers extensively during HB 33. It is our understanding ORC 5122.36 (B)(3) indicates OhioMHAS will accept national accreditation as meeting state requirements as is currently in place today under deemed status. As drafted, we are concerned this rule language for onsite reviews, while permissive, walks back on the understanding that achieving national accreditation would reduce the state regulatory requirements and opens the door for interpretation that OhioMHAS certification will also include an onsite review.

To be clear, we have no concerns with the language in (D)(1)(b). It is prudent to conduct onsite reviews when there is just cause, a complaint, or allegations or confirmation of deficiencies.

Recommendation: Remove paragraph (D)(1)(a) or make changes to language so that this provision is only applicable to services that are not covered by national accreditation. This could read, "The director may conduct an on-site review of the applicant for services or supports the department has determined that national accreditation is not available or required."

5122-25-04 – Certification procedure – renewal application

3. Paragraph B(1)(e) outlines renewal application requirements and requires submission of the applicant's budget. As noted above, this is not a requirement today for providers that have national accreditation. Further, OhioMHAS rule5122:1-3-05 (D)(1)(c) requires certified programs to complete and submit an independent financial audit statement so OhioMHAS has sufficient financial information, and a budget statement is not necessary.

   Recommendation: Remove the requirement for an applicant to submit their budget.

4. Paragraph (D) offers similar language as in 5122-25-02 (and commented on in item two (2) above) that introduces permissive language that implies OhioMHAS is rolling back regulatory relief and opens the door for duplicative on-site reviews for organizations with national accreditation. Additionally, for renewal applications, this rule requires rather than permits the inclusion of an ADAMH board in the review process. In the initial certification rule, the language is permissive regarding inclusion of the ADAMH board. Further, according to ORC 5119.36 (A), the director may conduct an onsite review in cooperation with the ADAMH Board and is only required to notify the ADAMH Board of receipt of the application.

   Recommendation: Remove paragraph (D)(1)(a) or make changes to language so that this provision is only applicable to services that are not covered by national accreditation and align with language in 5122-25-02(D)(1)(a). Further, clarify that the director has permissive authority to include an ADAMH board in onsite reviews.

5122-25-08 – Probationary Certification

5. In (E) and (F) there are references to "interim certification" which we believe is intended to be "probationary certification". We recommend updating the language.

5122-26-06 – Human resources management

6. Paragraph (D) outlines requirements to verify licenses, credentials, etc., this section should also clearly include that primary source verification includes online verification systems as these have

become more widely available, such as the Ohio e-license system. As this rule currently reads someone could interpret this language to require a physical copy of an employee's credentials.

Recommendation: Add language indicating verification through online primary source methods is acceptable.

7. Paragraph (E)(2) adds a new requirement for providers to conduct background checks every 4 years on all employees, not just those serving children. We are unaware of a state requirement for background checks of all employees other than those serving children and youth that would support this requirement. This will impose an added cost to all provider organizations that does not exist today and may be inconsistent with national accrediting body requirements.

   Recommendation: Apply the requirement for repeated background checks to only apply to those providers offering services to children or adolescents.

8. Paragraph (G) outlines new requirements applicable to adults, to review criminal charges prohibited by children's services agencies and recommends reviewing an EEOC website for guidance, for which the hyperlink included in this rule does not correctly redirect to the website. Additionally, this new language will create confusion as it is in conflict with the ODM exceptions for licensed providers/peers under ORC 5164.34 (I) and 5160-1-17.8 (A)(1)(d) and OhioMHAS rules for peer certification in 5122-29-15.1. While this rule does not specifically prohibit adult service providers from hiring people with past criminal convictions, it strongly implies providers should engage in practices that contribute to further collateral sanctions even for those that are in recovery.

   Recommendation: Align language in this section with the criminal conviction exceptions outlined in OAC 5160-1-17.8 and for peers in OAC 5122-29-15.1.

9. Paragraph (J)(1)(b) continues the existing requirement of 20 hours of continuing education for non-licensed/certified providers. However, the new QBHS rule, 5122-26-21, requires 30 hours of continuing education, as does peer certification. However, it's not clear if OhioMHAS intends for this section to apply to administrative, non-licensed staff or if OhioMHAS is signaling their intent to develop a QBHS credential. Further, OhioMHAS peer services are not currently certified by a professional licensing board, so this may create another conflict. If not, the continuing education requirements should be aligned with other non-licensed/credentialed staff to limit confusion and disparity among non-licensed/credentialed staff.

   Recommendation: Reword and clarify the intent and applicability of language for continuing education requirements for non-licensed/certified providers.

5122-26-13, Appendix A – Reportable and Six-Month Reportable Incidents

10. First, we would encourage OhioMHAS to track proposed changes in this appendix document to support full transparency as is done for rule text. Unless the reader happened to read the "rule memorandum for initial public comments" that was only posted on the Departments webpage and easily overlooked, it would be easy to miss these very significant changes and additions of 6 new reporting requirements.

    The proposed changes in Appendix A to this rule require six new reportable incident types that are likely to significantly increase the frequency and quantity of reported incidents. While we understand

the importance of incident reporting, we question why some of these categories are being added and would like to understand how OhioMHAS determined these categories rise the necessity of being "major" or "unusual" enough to warrant reporting to OhioMHAS. Adding these reporting categories will require additional administrative time and resources to review reports by the provider, ADAMH Board(s), and OhioMHAS, adds costs for IT system enhancements and training, and the expansion of categories requires careful consideration of the definition and expected gains of requiring reports.

As an example, OhioMHAS worked closely with stakeholders more than a dozen years ago to streamline incident reporting and intentionally removed two of the proposed additions, suicide attempts and AWOL. Returning these two categories is another example of rolling back existing regulatory relief.

AWOL was previously removed as individuals receiving care have the right and freedom to choose not to participate in treatment or return for care at a prescribed time. As such AWOL created a conflict with client rights and is addressed through treatment and safety planning and in conjunction with parents or legal guardians of minors.

As drafted the definition of suicide attempts is expansive and would result in significant increases in reporting as it doesn't differentiate between minor gestures or acute, severe attempts that may require medical attention or chronic cutting or suicidal behavior for which there is already a defined crisis plan. Requiring reporting on any suicide attempt would be similar to asking hospital emergency departments to report every patient that presents with chest pain rather than only those that experience a heart attack. Unfortunately, it is routine to provide services to individuals that present with suicidality and in many cases such behavior is addressed through the treatment plan. Historical reporting was limited to suicide attempts requiring medical intervention.

Similarly, we question the true value of adding a category for accidental overdose, survived and how a provider would differentiate this category from a suicide attempt, other than patient report. And the new sub-category of accidental death resulting from an accidental or unintentional overdose will be equally difficult to determine as many times this information is not available until and unless an autopsy is completed. Providers do not readily have this information available in reliable formats. This is another area where input from clinical practice in community settings is necessary to inform policy and rulemaking.

Further, we would like to understand the difference between the new medication diversion category from the missing/unaccounted for medication category. Other than semantics, this appears on face value to be capturing the same information. And we would like to understand the circumstance and conditions that resulted in adding a category of selling drugs on premises and how that may be different from medication diversion. These definitions lack clarity and appear to overlap. Further, we have concerns that adding reporting requirements may create a barrier for an individual to access care due to concerns treatment may result in engagement of law enforcement.

Recommendation: Remove reporting of all suicide attempts and AWOL consistent with previous regulatory relief efforts to support clinical practice. Clarify definitions and combine where appropriate to clearly articulate discrete and unique actions that are "major" or unusual" to rise to level of statewide reporting. Make sure any reporting does not increase barriers for accessing care.

5122-26-18 – Client rights and grievance procedure

11. Paragraph (I)(1) adds a new requirement for organizations that at least one person who can accept a client grievance must be on site during business hours. This addition assumes clients prefer or expect to grieve only "in person" or fails to appreciate the various size and hours of operations of provider organizations, staff absences or cross coverage considerations, and the increased reliance on written, electronic, and telehealth communication preferences of the clients. We understand the importance of onsite client grievance staff but recommend more flexibility in this new requirement. Additionally, it is noteworthy that most clients submit grievances either in writing or by making a phone call and may not prefer to file a grievance in person.

    Recommendation: Change language in paragraph (I)(1) to mirror language in (I)(2) related to the "core number of hours each day the provider organization is open"

5122-26-21 – Qualified behavioral health specialists

12. Generally, this new rule represents a substantial change from current education and training requirements and is significantly more onerous, prescriptive, expansive, and largely in conflict with existing rules governing Ohio Medicaid and OhioRISE practitioner enrollment training. As currently written, this rule is likely to result in an immediate and severe reduction in the QBHS workforce based on the newly expanded training and education requirements, supervision caseload limits, and higher levels of clinical supervision. It appears this rule intends to create certification requirements without providing an actual certificate or credential and fails to offer a means of tracking, documenting, or supporting practice across multiple employer settings. The rule is silent on whether training is transferable across employers or practice settings or must be repeated by each provider organization for each employee as a means of demonstrating compliance. Further the reference to required use of e-based academy for the initial 16 hours of training is concerning as most provider organizations rely on existing learning management systems to track training and educational requirements, including required trainings. Requiring a state defined and managed system creates significant operational challenges and costs that do not exist today. It is unclear if the intent of this rule is that all training for QBHS staff moving forward will be required to be completed in e-based academy.

    Further, this new rule conflicts with requirements set forth by Ohio Medicaid in 5160-27-01 and 5160-59-03.2 and will disrupt a wide range of Medicaid covered services and supports.

    Recommendation: While we appreciate the need to create a career pathway for QBHS, this regulatory approach is insufficient as it does not offer a credential. This approach adds costs and requirements that cannot be met in the current workforce environment and will disrupt service delivery and access. We strongly recommend pausing this rule change and restoring the existing requirements either in 5122-26-20 or in this rule.

13. As drafted, there is no grandparenting provision for existing QBHS staff or an identified glidepath for current staff to come into compliance with these new requirements. This needs to be outlined specifically or it will cause significant disruption in the services provided by all existing QBHS staff. According to Medicaid provider enrollment data from February 24, 2024, there are approximately 45,000 individual providers enrolled in community mental health centers and approximately 36,000 individuals enrolled in community addiction services providers. There are over 18,000 QBHS staff

enrolled in community mental health centers and over 9,000 QBHS staff enrolled in community addiction treatment centers. This demonstrates the sizable impact this rule will have on the QBHS behavioral health workforce and the likelihood of disruption of care.

Recommendation: Pause this proposed change until a process with timelines for current QBHS staff to complete any new training requirements is established.

14. Paragraph (B)(1) outlines the requirement for 16 hours of training through e-based academy prior to contact with a client or resident. We assume this is the OhioMHAS e-based academy, although this is not clearly defined in the rule. The trainings in (B)(1)(a) – (k) appear to be titles of training content with very prescriptive hours rather than general topics that may be tailored to the population being served. Then (B)(2)(a) – (j) outlines specific training areas with prescriptive and inflexible time requirements that may be course titles but does not appear to require completion in e-based academy. While some organizations will appreciate and benefit from what appear to be standardized trainings, many organizations have purchased and developed learning management systems (LMS) through which they manage and deliver training content, including QBHS training curricula that cover these topics and are tailored to their communities and populations served. We recommend maximum flexibility in the training requirements to allow for existing training programs developed by organizations and the ability to transfer any standard training content into their existing LMS so as not to disrupt existing HR monitoring functions. Additionally, while we may agree with some of the subject matter outlined for training, this section is overly prescriptive in outlining the amount of time for each topic. For example, paragraph (B)(2)(j) requires three hours and ten minutes of training in "growth and change of a QBHS". Training programs are not typically designed to include ten-minute intervals.

    Further, the language in (B)(1) that does not allow client/resident contact until the 16 hours of phase 1 training courses are completed does a disservice to new QBHS staff and is not in line with many existing onboarding programs. Many organizations include shadowing current staff, with client/resident permission, during the first week of training as a hands-on way to learn their job expectations. New staff are not intervening, but simply observing. In this labor market, new employees are more likely to be retained if they have an engaging onboarding experience. Requiring the first several days of employment to be online training only, without any interaction with other workers or in the work setting with clients is counterproductive and inconsistent with best practice.

    Recommendations: Change language in (B)(1) to make the use of e-based academy optional and remove the limits on client contact during phase 1. Generally, in (B)(1) and (2) remove the detailed time descriptions with exceptions for key topics such as ethics and boundaries, cultural competence, and trauma-informed care and make any standardized training material transferable to provider LMS.

15. Paragraph (D) introduces new requirements allowing only independently licensed clinicians to supervise a maximum of eight QBHS staff. As drafted, this conflicts with supervision requirements in 5160-27-01 (A) and (D) and 5160-59-03.2 (E). Not only is this unnecessary, but it will be detrimental to current QBHS staff and teams, further limiting the availability of services in Ohio. There are well documented workforce shortages and there are not sufficient numbers of independently licensed clinicians in community behavioral health to supervise all the QBHS staff, let alone all the other dependently licensed staff that require supervision or to provide direct clinical treatment to those in need. As previously mentioned, QBHS staff represent a significant portion of the community-based

behavioral health workforce. However, based on the same Medicaid provider enrollment information, there are only 6,000 independently licensed clinicians in community mental health centers and approximately 4,500 independently licensed clinicians in community addiction treatment centers. Not every independently licensed clinician is or wants to be a supervisor, nor do they all work full time. Both changes will impose new restrictions on a vital component of the behavioral health workforce. Further, this rule proposes to establish a maximum supervision ratio of 1:8 which again is not sustainable, does not consider other programmatic requirements, nor does it take into consideration the variation in populations served or services being provided. There is no evidence to support this expectation that has been documented or shared.

Recommendation: Align eligible supervisors in paragraph (D) with 5160-27-01(D) and 5160-59-03.2 (E). Remove limit of eight supervisees to each supervisor.

16. We appreciate efforts to create a code of ethics in (E), however, we are concerned that this language is not enforceable, nor does it provide the same patient and community protections as it would if under the auspice of a professional licensing board. There is no recourse to the individual, only the certified provider organization, for failure to follow this section.

    Recommendation: Pause this proposed rule change to develop a credential process that offers the intended protections.

17. Paragraph (E)(8) prohibits QBHS staff from "sexual or intimate activities with colleagues". This new provision represents government overreach into the personal freedoms and private lives of individuals. There is not another practitioner type in the community behavioral health system that has a state rule dictating and explicitly prohibiting their personal relationships. Certainly, many organizations have policies that outline acceptable employee relationships, but that is not policy the state government should be establishing. Additionally, this provision does not contemplate the reality of the current labor market that organizations, especially in smaller communities, hire spouses and family members of employees who would be impacted by this change should it remain as written.

    Recommendation: remove "with colleagues" from paragraph (E)(8).

5122-27-03 – Treatment Planning

18. The proposed changes to this rule remove current requirements for a substance use case management plan to be completed every 90 days. However, federal Medicaid regulations for targeted case management require completion of a case management plan every 90 days. Given the intent of cross referencing between OhioMHAS and Ohio Medicaid regulations, we recommend restoring this expectation for SUD case management plans in this rule.

    Recommendation: Restore language requiring completion of SUD case management plans every 90 days consistent with federal targeted case management regulations.

19. Paragraph (B)(7) adds a new requirement specifically indicating the signature of a supervisor must be present on the treatment plan. The existing requirement allows for "documented evidence of clinical supervision of staff completing the review". We recommend maintaining this language based on the

many and varied electronic health record systems and variety of service pathways used to access and document care across the industry. For some organizations, this may be a simple change. However, for others this will add additional work and require updates to their electronic health record to implement these changes. Some organizations utilize the progress note or other documentation within the client record to document review and approval of the treatment plan.

Recommendation: maintain existing language allowing documented evidence of clinical supervision as opposed to specifically indicating a supervisor must sign the treatment plan. Clarify that electronic signatures are acceptable.

5122-27-04 – Progress Notes

20. The proposed changes in paragraph (B) remove existing flexibility to document services on a weekly basis. While this is not the typical documentation pattern for many outpatient services, weekly progress notes are often used in higher levels of care such as residential programs.

    Recommendation: retain language in the existing rule allowing weekly documentation.

5122-27-05 – Discharge Summary

21. Paragraph (B)(6) makes slight adjustments to existing requirements and now requires outcomes from each service a client received. Most clients receive several services, and the discharge summary is a clinical tool reflects the overall outcome of treatment inclusive of all services or the level of care completed. We strongly recommend supporting whole person care models that recognize the totality of care is what achieves success. As an example, we cannot discreetly delineate how much reduction in depression is attributed to individual therapy vs. medication management. Both services combined contributed to the outcome of reduced symptoms of depression.
    Recommendation: retain existing language, Outcome of the service provided, i.e. amount of progress or the level of care.

5122-27-06 – Release of information

22. Paragraph (B)(10) indicates a general authorization is not sufficient for the purposes of 42 CFR 2 and that further disclosure is not permitted. However, this appears to be out of date with the recently released HHS guidance. We understand this is likely a timing issue between the drafting of this rule and the release of the updated 42.CFR part 2 requirements, which will have a delayed effective date.

    Recommendation: Amend this language to reflect updated federal requirements with delayed timeline for implementation.

Thank you for considering our extensive comments and feedback. As indicated above, we seek to schedule a meeting with OhioMHAS legal and policy leadership to discuss this rule package and understand the intent of some of these rule changes and address concerns so we may work collaboratively to support implementation of needed or necessary changes. We look forward to finding time in the near term to further discuss our comments, questions, and concerns.