The Ohio Council
Of Behavioral Health & Family Services Providers

17 S High Street, Suite 799, Columbus, OH 43215
614-228-0747 | www.TheOhioCouncil.org
@theohiocouncil

Comments on Proposed Rule Amendments
OAC Chapter 5122-24, 5122-25, 5122-26, 5122-27, and 5122-28
Teresa Lampl, LISW-S
October 29, 2024

The Ohio Council of Behavioral Health and Family Services (the Ohio Council) appreciates the opportunity to provide feedback on the Ohio Department of Mental Health & Addiction Services' (OhioMHAS) proposed five-year rule review changes. The Ohio Council is a trade and advocacy association representing more than 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. We greatly value our partnership with OhioMHAS and appreciate the opportunity to meet and discuss our prior concerns regarding the pre-clearance rules and our comments submitted earlier this year. We recognize the significant revisions made to the initial proposed rule package following the previous comment period. We are grateful that OhioMHAS understood the potential impact these changes could have had, including increased administrative burdens, higher costs for behavioral health organizations, and potential effects on the availability of services.

However, several provisions within this rule package continue to raise concerns regarding the rollback of long-standing regulatory relief efforts and the unnecessary expansion of costly regulations. These changes pose substantial operational challenges that are likely to have an adverse effect on behavioral health organizations, further complicating efforts to attract and retain the community behavioral health workforce. Ultimately, exacerbating the most significant challenge that hinders access to care for Ohioans in need.

We would like to schedule a meeting with CSI staff, OhioMHAS legal and policy leadership, respectively, to discuss this rule package and to better understand the intent of changes made through HB 33 as well as some of the other proposed changes so we may work collaboratively to support the implementation of any changes. We appreciate OhioMHAS' willingness to engage stakeholders, including the previously scheduled meetings on the initial rule package, and find these meeting valuable in aligning regulations with the intended regulatory practices. In the interest of collaboration, we are submitting these comments to seek clarification, raise concerns, and where possible, offer additional recommendations to address specific challenges of the proposed rules and facilitate their adoption and effective implementation by community behavioral health providers.

Below, we have associated our comments with the proposed rules, and we have placed our comments in the order in which topics appear.

5122-25-02 Certification procedure – initial application

1. In (B) (1)(b), the language added in parentheses is confusing and we are concerned that the Department is now defining how a business must set up its corporate structure, which would be a significant governmental overreach. The term "agency" is not defined and is an outdated term, and it is unclear how this language is to be interpreted since a provider organization can have multiple sites and multiple business lines.

   Recommendation: Simplify. Remove all language in parentheses to simply require submission of the federal tax identification number as is current practice.

2. In (B)(1)(d)(iv) the term "agency" appears again.

   Recommendation: Replace agency with the word "provider" for consistency with the definitions in 5122-24-01.

3. The Ohio Council has long supported national accreditation as a vehicle to improve quality of care and overall operations of behavioral health services in Ohio. While national accreditation increases administrative practices and includes sizable survey costs for provider organizations, the value it adds through an intentional focus on patient care, continuous quality improvement, and measurable outcomes is essential in today's business environment. We view the cost of national accreditation as a necessary investment in organizational and clinical quality.

   As background, in 2003, the Ohio General Assembly supported legislation that required all community mental health centers to achieve national accreditation as a condition of receiving state certification through what was then the Ohio Department of Mental Health (ODMH), and in doing this, the state of Ohio agreed to accept national accreditation as meeting state certification standards through "deemed status" thereby providing significant regulatory relief by removing redundant, time consuming, and administratively burdensome on-site reviews by the ODMH. By 2006, all state certified community mental health centers achieved and operated with national accreditation. In 2011, the General Assembly approved statutory language authorizing the former Ohio Department of Alcohol and Drug Abuse Services (ODADAS) to accept national accreditation as meeting state certification through deemed status for state certified substance use treatment providers, - thereby extending the same regulatory relief to these other providers. When ODMH and ODADAS merged, in 2013, the General Assembly decided to adopt statutory language permitting the new consolidated department, OhioMHAS (formerly ODMH and ODADAS) to accept rather than require national accreditation as meeting state certification through deemed status for certification of either mental health and/or substance use services – again, maintaining the regulatory relief. After 2013, most OhioMHAS certified providers that achieved national accreditation continued to maintain and value national accreditation as a standard of excellence and commitment to quality improvement practices. There were no noted concerns by OhioMHAS or other regulators with national accreditation or deemed status. However, by 2020 with the exploding opioid epidemic, the COVID pandemic accelerating demands for behavioral health services, increased use of telehealth as means of service access, and an influx of new out-of-state addiction treatment providers, it became clear that greater oversight to ensure patient safety and updated efforts to address quality of care concerns warranted the extension of mandatory national accreditation to operate in Ohio.

As such, the Ohio Council fully supported OhioMHAS in its efforts to require national accreditation as a state certification for mental health and substance use disorder services in section 5119.36 of the Revised Code as enacted in HB 33. Further, we also supported the language to require adequate staffing and notification on adverse action taken against an applying certified organization in the previous three years as additional requirements for state certification. However, in our support of this effort in HB 33, we understood that OhioMHAS would continue to accept national accreditation, demonstration of adequate staffing, and no adverse actions pending or taken against the applicant/certified provider as meeting the conditions for certification without further onsite review. On-site reviews conducted by OhioMHAS would only be required for those services for which national accreditation does not exist or at any time based on cause.

We continue to have significant concerns with the Department's drafting of language in (D) and (D)(1) of this rule and the implementation of statutory changes enacted in HB 33 under section 5119.36 of the Revised Code. We contend that by reorganizing the order and progression of sentences in the rule differently than presented in the statute, it serves to change legislative intent in a manner that has the potential to overturn 20 years of regulatory relief and creates a scenario that will substantively and significantly increase regulatory burdens on nationally accredited providers seeking OhioMHAS certification. Further, it would likely divert provider resources from patient care through increasing costs to prepare for and participate in onsite reviews. Moreover, this proposed rule would require greater OhioMHAS staff resources and staggering increases in state administrative costs associated with conducting such onsite reviews that are not part of the process today. Finally, we are concerned that these new regulatory hurdles and increased administrative costs will fall squarely on the community behavioral health provider community in the form of new and increased certification fees – see CSI/BIA document at pages 19 and 20. .

Language in (D) of this rule only speaks to determining whether an application is complete and compliant – it does not address the statutory requirement of 5119.36 that the director determine that the standards for national accreditation defined in (B) of the section and requirements for adequate staffing and no adverse actions defined in (C) of the section, or any other rules adopted under this section have been met. Presently, determinations for certification are met by review of the application without the need for an onsite review when national accreditation is present.

Then (D)(1) assumes an onsite review is always part the determination for certification and does not contemplate the language in 5119.36 (D) of the Revised Code that explicitly says *certification shall be issued without further evaluation of services or support when certain conditions are met*.

While the language in ORC 5119.36 (A) certainly gives the director permissive authority to conduct onsite reviews of an applicant for initial certification or certification renewal, the plain reading of the language preceding the permissive authority for onsite reviews indicates that the director is to determine the requirement for national accreditation defined in (B) of the section and requirements for adequate staffing and no adverse actions defined in (C) of the section, and any other rules adopted under this section are satisfied by the applicant or renewal. The permissive authority for an onsite review is limited to determining if national accreditation is in place or there are questions about staffing or adverse actions. Further, language in ORC 5122.36 (D)(1) says that the director *shall issue or renew the certification without further evaluation of the services and support when a fee has been paid, national accreditation is appropriate, and the provider has adequate staffing and is not under subject to any other adverse action.* See language below - emphasis added.

> ORC 5119.36 (A) A person or government entity that seeks initial certification of one or more certifiable services and supports, or that seeks to renew certification of one or more certifiable services and supports, shall submit an application to the director of mental health and addiction services. ***On receipt of the application, the director shall determine whether the standards established by divisions (B) and (C) of this section and any rules adopted under this section are satisfied or continue to be satisfied by the applicant***. As part of the determination the director *may* conduct an on-site review of the applicant.
>
> ORC 5119.36 (D)(1) If the director determines that an applicant has *paid any required certification fee*, *that the applicant's accreditation of certifiable services and supports is current and appropriate for the services and supports for which the applicant is seeking initial or renewed certification*, *that the applicant meets the requirements of division (C) of this section*, and *that the applicant meets any other requirements established by this section or rules adopted under it*, the director shall certify the services and supports or renew the certification of the services and supports, as applicable. **Except as provided in division (J) of this section, the director shall issue or renew the certification without further evaluation of the services and supports**.

As such, starting (D)(1) of this rule with the presumption of an onsite review significantly changes the meaning and intent of the statutory language implying that the onsite review is the expectation not an exception to be used only when the plain fact determination of national accreditation, determination of adequate staffing, or determination of adverse actions cannot be immediately satisfied by the application. The proposed rule at (D)(2) implies that the onsite review extends beyond review of services and supports that do not have a national accreditation equivalent and could review services and supports that are nationally accredited. Further it may conflict with the statutory language in 5119.36 (D)(1) that indicates the issuance or renewal of the certificate shall be provided without further evaluation of the services and supports when a provider has national accreditation, adequate staffing, no adverse actions exist, and has paid the requisite application fee.

Based on discussions with OhioMHAS staff, we understand that the Department does not intend to require onsite reviews for providers holding national accreditation. However, the current language of the rule implies that an onsite review is still presumed or for these accredited providers and is not consistent with the current or future expected regulatory practice.

Recommendations: Revise paragraph (D) to address determination for compliance with the requirements of 5119.36 (B) and (C) not just whether an application is complete and compliant.

Further, revise (D)(1) to include ORC 5119.36 (A) and (D). We would suggest the following language:

In (D)(1)(a) "If the director determines the standards of (B) and (C) of 5119.36 of the Revised Code have been met through the application, the director shall proceed without further evaluation of the services and supports. The director may conduct an onsite review of the applicant if additional information is needed to confirm (B) and (C) of 5119.36 of the Revised Code have been met."

In (D)(1)(b) add at the end of current language, "for certifiable services and supports for which national accreditation does not exist."

No change to (D)(1)(c) – we fully support for cause onsite reviews.

5122-25-03 Certification procedure – update application

4. Same as comment #3 above, we recommend amending the language in (C)(1) and (2) to align with ORC 5119.36 (A) and (D).

   Recommendation: Revise (C)(1) to read, "If the director determines the standards of (B) and (C) of the Revised Code have been met by submitting the updated application, the director shall proceed without further evaluation of the services and supports. The director may conduct an onsite review of the applicant if additional information is needed to confirm (B) and (C) of the 5119.36 of the Revised Code have been met."

   In (C)(2), add at the end of the current language, "for certifiable services and supports for which national accreditation does not exist."

5122-25-04 Certification procedure – renewal application

5. In (B)(1)(b), we have the same concerns as noted in comment #1 above. We do not believe it is prudent to specify a business's corporate structure through parenthetical comments and there is no definition of the term "agency" which is confusing.

   Recommendation: Simplify. Remove all language in parentheses to simply require submission of the federal tax identification number as is current practice.

6. Same concerns with (D), (D)(1)(a), and D(1)(b) as noted in comment #3 above. We recommend amending the language in (D) to align with ORC 5119.36 (A) and (D) as described below.

   Recommendation: Revise paragraph (D) to address determination for compliance with the requirements of 5119.36 (B) and (C) not just whether an application is complete and compliant.

   Further, revise (D)(1) to include ORC 5119.36 (A) and (D). We would suggest the following language:

   In (D)(1)(a) "If the director determines the standards of (B) and (C) of 5119.36 of the Revised Code have been met through the application, the director shall proceed without further evaluation of the services and supports. The director may conduct an onsite review of the applicant if additional information is needed to confirm (B) and (C) of 5119.36 of the Revised Code have been met."

   No change to (D)(1)(b)(i) since the provider has not yet attained national accreditation.

   In (D)(1)(b)(ii) add at the end of first sentence in the current language, "for certifiable services and supports for which national accreditation does not exist."

   No change to (D)(1)(c) – we fully support for cause onsite reviews.

5122-25-11 Refusal and revocation of certification

7. As drafted, (A)(1) could result in refusal or revocation of certification for any singular compliance issue, regardless of how minor, across five chapters of rules and without any opportunity for a plan of correction or remedy. Other sections of this paragraph address major or significant concerns, which we agree are likely grounds for more immediate action. We recommend adding guardrail language to at a minimum provide notice and an opportunity for a plan of correction, which is the Department's current practice.

   Recommendation: In (A)(1) at the end of the current language add, "for which a plan of correction has not been satisfied."

5122-25-12 Certification fees

This rule was not part of the previous draft rule package shared with stakeholders in March 2024. Consistent with our concerns in comment #3 above, the proposed certification fee structure equally accelerates costs associated with undoing regulatory relief. The CSI BIA indicates on page 19 that the proposed fee structure has an adverse impact specifically due to the costs associated with increased oversight – mostly with what we anticipate is more onsite reviews by OhioMHAS, that we have concerns with as described above.

Further, the cost to a provider organization to attain and maintain national accreditation, which will be required by October 1, 2025, is upwards of $10,000 (more for organizations with multiple sites/locations and service arrays) – and this cost does not include the staff time for training, management, performance improvement, or administrative activities to support national accreditation. Today, certification fees do not apply for services for which national accreditation exists – so this will be a new cost imposed by the Department. Certainly, inflation is impacting all of us, including governmental agencies. However, the proposed fee is overly complicated and is not aligned with the intent of 5119.36 (A) and (D), which for organizations with national accreditation would not receive an onsite review unless specific additional information is needed. We would recommend the following changes:

8. In (A), we would be willing to support a base fee of $1,000 since the department would have to administratively set up the provider organization account and review all initial information. However, we oppose a per service fee for services that are nationally accredited. OhioMHAS has a published crosswalk that defines the accreditation that meets state certification requirements, and by practice has indicated it does not routinely intend to provide onsite reviews for those services. Requiring a fee for nationally accredited services is duplicative, not collected today, and an unnecessary added cost burden for a provider.

   Recommendation: Remove (A)(2) or replace with a statement that per service fees do not apply for services that have national accreditation.

9. In (B), similar to comment #8 above, OhioMHAS has a crosswalk that defines the national accreditation standards that meet state certification requirements. Requiring a fee for national accredited services is duplicative, is not collected today, and an unnecessary added cost burden for a provider.

Recommendation: Remove (B)(1) or replace with a statement that per service fees do not apply for services that have national accreditation.

10. In (C), similar to comment 8 above, we would be willing to consider a nominal renewal application fee of $500 or less to cover administrative costs of reviewing the renewal application. However, we oppose a per service fee for services that are nationally accredited. OhioMHAS has a published crosswalk that defines the accreditation that meets state certification requirements, and by practice has indicated it does not routinely intend to provide onsite reviews for those services. Requiring a fee for nationally accredited services is duplicative, not collected today, and an unnecessary added cost burden for a provider.

    Recommendation: Remove (C)(1) or place with a statement that per service fees to not apply for services that have national accreditation.

5122-26-06 – Human resources management

11. Paragraph (A) amends the definition of personnel and no longer includes volunteers or student interns. While the proposed languages states "whether the individual is paid or not paid" it also specifically indicates that the person is "employed or under contract" with the organization, which generally does not apply to either volunteers or interns. Volunteers and interns should be included in the definition of personnel as a protection to patients and to reduce administrative burden to behavioral health businesses. Additionally, volunteers and interns are referenced specifically throughout this rule with no definition if they are not included in paragraph (A).

    Recommendation: Add language to include volunteers and students interns in the definition of personnel.

12. Language in (I)(3) requires direct service staff requiring supervision to receive "face-to-face" supervision in accordance with requirements established by their issuing professional licensure board. However, since the COVID-19 pandemic, professional licensure boards often permit supervision to include video conferencing or phone calls as meeting a "face-to-face" requirement. This flexibility has become an essential tool for supervision of many direct service staff requiring supervision.

    Recommendation: Specifically clarify that "face-to-face" supervision may include supervision provided by videoconferencing or phone calls.

5122-26-12 – Environment of care and safety

13. Paragraph (C)(3)(b) adds a new requirement for tornado drills to be conducted at least semiannually. We understand the importance of safety drills as a component of emergency planning and safety. However, the requirements related to similar drills are to be conducted annually. We recommend this new requirement aligns with existing timeframes for ease of implementation, consistency, and reduction of interrupted patient care and business operations.

Recommendation: Change language in (C)(3(b) to “at least annually”

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

14. The proposed changes in Appendix A to this rule require eight 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 continue to question why some of these categories are being added as they are fairly common occurrences in the typical course of treatment of mental illness and addiction and are not necessarily “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 and the meaningful use of the data to improve practice.

    As an example, OhioMHAS worked closely with stakeholders more than a decade ago to streamline incident reporting requirements and intentionally removed two of the proposed additions, suicide attempts and AWOL (absent without leave). Returning these two categories is another example of repealing 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.

    We appreciate the clarification that reporting of suicide attempts is applicable only to class one and SUD residential facilities. However, as drafted, the definition of suicide attempts remains overly broad and would result in significant increases in reporting as it does not 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 continue to 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 and may not have access to this information definitively.

Further, 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. Similarly, medication diversion and drug theft are equally similar and OAC 5122-26-15 Medication handling and theft does not mention medication diversion – only theft. 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: In Appendix A: 1) Remove reporting of AWOL consistent with previous regulatory relief efforts to support clinical practice. 2) Add language that suicide attempts in class one and SUD residential facilities shall be reported when medical intervention is required. 3) Remove medication diversion as it's addressed under medication theft. 4) 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. 5) Evaluate potential barriers for accessing care created by expanded reporting. 6) Outline how OhioMHAS will make available aggregated reporting information to providers as a method of benchmarking and improving quality on a regular basis. 7) Define the cost of updating OhioMHAS' electronic reporting system, and all downstream costs for IT system updates for ADAMHS Boards and certified providers to manage reporting and expected investigations and quality assurance processes.

5122-26-15 Medication handling and theft

15. Language in (A)(3) seems unnecessary, confusing, and duplicative of requirements in (C).

    Recommendation: Remove (A)(3).

5122-26-20 Eligible providers and supervisors

16. Paragraph (C) of the proposed rule aligns with paragraph (C) of the current rule (5122-29-30) and permits Qualified Behavioral Health Specialists (QBHS) to provide eight services: Mental Health (MH) day treatment, Substance Use Disorder (SUD) case management, Mobile Response and Stabilization Services (MRSS), Community Psychiatric Supportive Treatment (CPST), Therapeutic Behavioral Services (TBS) and Psychosocial Rehabilitation (PSR), Intensive Home-Based Treatment (IHBT), and Assertive Community Treatment (ACT). Crisis providers have recommended adding Behavioral Health Hotline Services (5122-29-08) to this list, as QBHS staff can be adequately trained to respond to hotline calls under the supervision of a licensed clinician. This recommendation is further supported by recent MRSS draft rules, which propose that QBHS staff may participate in a team mobile response with another QBHS or peer, while under the supervision of a licensed clinician — representing a similar or even more intensive crisis service. Given that QBHS staff will be permitted to respond onsite to crises under clinical supervision, it logically follows that they should also be eligible to respond to crisis calls under similar oversight.

    Recommendation: Add Behavioral Health Hotline Services to paragraph (C).

5122-26-21 – Qualified behavioral health specialists

As previously mentioned, we appreciate the collaboration and the thoughtful consideration of our prior comments, and we acknowledge the significant revisions made to this rule since its initial release. However, we remain concerned about several changes that we believe will negatively impact current practices, the delivery of services, and the behavioral health workforce.

17. Paragraph (A) defines a QBHS as only providing "care coordination, client monitoring, or both." This abbreviated definition of the services provided by QBHS staff not only diminishes the services and the important work of these key treatment team members, but more importantly will impact the services available to patients in need of treatment. The current QBHS standards outlined in 5122-29-30 require basic competencies in several key areas, which are directly related to the services QBHS staff currently provide, including crisis response, de-escalation, and the use of therapeutic engagement to teach skills and educate patients on their diagnoses and available resources, which is a much broader scope than merely care coordination and client monitoring.

    Given that QBHS staff are permitted to provide a wide range of services as outlined in 5122-29-30 and the proposed 5122-26-20, paragraph (C), the language in this rule should similarly be broad and inclusive of all the services these staff are authorized to deliver. Additionally, the training requirements in paragraph (D)(3)(g) of the proposed rule include competencies that suggest the provision of services beyond care coordination and client monitoring. Restricting QBHS staff to care coordination and client monitoring would represent a significant reduction in the scope of services currently provided by these valuable team members. This change would necessitate extensive programmatic overhauls for organizations and negatively impact workforce availability for delivering several essential services. The effect would be a seismic disruption of care leaving many clients without care providers necessary for them to remain in home and community settings.

    Recommendation: Modify language in paragraph (A) to "QBHS is an individual who provides an array of service activities, to address individualized mental health and substance use needs of a person served to promote recovery, develop skills, manage and monitor symptoms and relationships, live and integrate in the community, and care coordination of healthcare, behavioral healthcare, and non-healthcare services".

18. Paragraph (F) introduces new requirements mandating that a licensed professional with a master's degree supervise QBHS staff. As drafted, this conflicts with allowed supervisors in 5160-27-01 (D)(13) Licensed Chemical Dependency Counselor II, (D)(14) Licensed Chemical Dependency Counselor III, and (D)(16) Licensed Social Workers, which includes professionals with bachelor's degrees. Further, case management and care coordination are not identified as services that require professional licensure or supervision. Additionally, 5160-59-03.2 (E), allows supervisors who are unlicensed practitioners to supervise care coordinators in the OhioRISE program. OhioRISE Care coordinators are QBHS staff. Requiring this change would impose a significant financial and operational burden on both behavioral health provider organizations and care management entities.

Recommendation: Address this rule conflict by revising language in paragraph (F) to be supervised by licensed professionals or as defined in OAC 5160-59-03.2 when employed as a care coordinator in the OhioRISE program.

5122-27-02 – Individual client record requirements

19. Section (D) speaks to the documentation that a provider of prevention services is expected to maintain. Documentation of prevention services is NOT maintained on an individual client basis, but rather is recorded in aggregated. We agree that maintaining aggregated documentation of prevention services as defined in this section is important; however, it does not fit in this rule which is specific to "individual" client records.

    Recommendation: Relocate language in (D) to another rule or section.

5122-27-03 – Treatment planning

20. Paragraph (A)requires the development of a **"comprehensive"** individualized treatment plan; however, the term "comprehensive" is not clearly defined and does not align with contemporary integrated treatment practices or the treatment planning standards set by the three accepted accrediting bodies. Treatment planning is a dynamic, ongoing process that is regularly integrated into the course of treatment and cannot be finalized in the same way as an assessment. Moreover, in primary care and other specialized care settings, care is frequently initiated following a brief, problem-focused assessment, with a treatment plan incorporated as part of that assessment and updated as medically necessary throughout the course of treatment often through progress or encounter notes. Imposing a requirement for "comprehensive" treatment plans that are significantly more detailed than those used in other healthcare settings as a condition for providing treatment services is not only counterproductive to patient engagement but also inconsistent with federal parity requirements. Earlier this year, The National Council for Mental Wellbeing joined the American Association for Community Psychiatry (AACP) and American College of Physicians (ACP) in calling for a review and revision of the treatment plan documentation requirements in behavioral health to promote better access to care, improve the patient care experience, and lead to better quality care that is in compliance with mental health parity requirements. The position statement is available here.

    Although not explicitly addressed in this rule or the newly proposed QBHS rule, The Ohio Council has received multiple reports from members indicating that OhioMHAS surveyors have informed some providers that QBHS staff are ineligible to develop treatment plans. This is despite the fact that treatment planning is a permitted activity under both the current QBHS regulation and the new proposed rule, as well as within CPST, TBS, MRSS, and Crisis Intervention service rules. While QBHS staff may not be authorized to complete an integrated treatment plan in its entirety (e.g., they cannot write therapeutic or medication-related goals), they are trained and competent to develop treatment plans related to the services they provide. This confusion, in part, stems from the various types of treatment and care plans developed across services, such as crisis plans, care plans, care coordination plans, SUD case management treatment plans, and traditional or medical treatment plans. While these different types of plans can be integrated into one document, they can also be created separately, and providers should have the flexibility to design treatment plans in the manner

that best meets the needs of the patient. As we continue to integrate behavioral healthcare into primary and other specialty care settings, our rules simply cannot create regulatory barriers to access or patient engagement.

Recommendation: Remove the undefined term of "comprehensive" from paragraphs (A) through (F) in this rule and in all other rules referencing "treatment plans" in Chapter 5122-27. Clarify that there is not a required format for treatment plans.

21. Paragraph (B) adds additional documentation requirements that are administratively burdensome and not conducive to patient care. The treatment plan should be utilized as a tool for patient engagement and to document treatment goals and progress, as opposed to a compliance-focused documentation checklist. For example, (B)(1) now requires a provider to include how services or supports will be provided or referred to another provider. These are administrative details that are more appropriate to be included in an organization's service plan as outlined in 5122-26-17, not an individual's treatment plan.

    (B)(7) adds a new burdensome 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 which ultimately result in increased administrative costs. Some organizations utilize the progress note or other documentation within the client record to document review and approval of the treatment plan.

    Recommendation: Remove new language added to (B)(1). Maintain existing language allowing documented evidence of clinical supervision as opposed to specifically indicating a supervisor must sign the treatment plan in (B)(7) or use the same language as in (G)(1)(b). *"other documentation satisfactory to the department that there has been clinical supervision over the development of the plan."*

22. Paragraph (F) requires the signature of an individual's supervisor and does not account for providers who are independently licensed and do not require the signature of their supervisor.

    Recommendation: Revise language to only require the signature of a supervisor, when applicable. "*The results are to be signed and dated by the provider staff member completing the review and that individual's supervisor, **if applicable."***

23. Paragraph (G)(2) outlines requirements for the development of a treatment plan after a provider's first face-to-face contact with a but does not specify if this includes telehealth visits.

    Recommendation: Define face-to-face in this section to include telehealth visits.

5122-27-04 – Progress notes

24. The proposed changes in (C) reflect another area where proposed changes are rolling back regulatory relief and increasing requirements. Previously, OhioMHAS demonstrated exemplary efforts to reduce documentation burden by applying the minimum federal requirements for documentation. Excessive documentation requirements are the leading cause of practitioner burn-out and is one of the top reasons clinicians leave practice in organizations regulated by OhioMHAS. This level and specificity of documentation is not required elsewhere in behavioral health, primary care, or specialty practices. Adding more requirements has a significant business impact that contributes to turnover and challenges in recruiting and retaining employees.

    As drafted, this language now mirrors the Ohio Medicaid rule 5160-08-05 (F), which is overdue for its Five-Year Rule Review, and for which the Ohio Council has and continues to seek regulatory relief to align with the current OhioMHAS rule and minimum federal requirements. See attached table for details. OhioMHAS rules have historically maintained a payer-agnostic approach. Aligning OhioMHAS requirements with those of a specific payer does not adequately reflect the diverse payer mix within behavioral healthcare. Adopting the more stringent Medicaid requirements for all payers imposes additional administrative burdens, which contributes to increased workforce strain and exacerbates burnout.

    Recommendation: Replace items in (C) with language from paragraph (D) of the rule that is currently in effect to maintain the minimum federal documentation requirements.

25. We appreciate that (B) now includes the ability to document notes on a daily or weekly basis, which is an important option that reduces regulatory burden. The current, in effect rule describes and permits the use of a service log and the elements that must be included since these will likely include multiple types of services and activities. Clarity is needed to support the use of logs and daily or weekly documentation.

    Recommendation: Restore language that clarifies use of serve logs is permitted and the required elements to support daily or weekly documentation.

5122-27-05 – Treatment summary

26. Paragraph (A) exemplifies the rollback of previous regulatory relief by re-introducing an arbitrary timeline for organizations to complete a treatment summary following the "end date of the client's course of treatment." This requirement is not aligned with modern care practices, which adopt an episodic approach and recognize that patients may return to treatment at various intervals, potentially exceeding the proposed 30-day timeframe to complete the treatment summary. This provision would disproportionately affect patients who temporarily discontinue treatment and return weeks or months later, where there is no clear "end date" for their care. Requiring the development of a treatment summary for any patient not seen within 30 days imposes an undue and unnecessary documentation burden on already overextended clinicians and creates barriers to rapidly resuming treatment for patients. While we acknowledge the importance of timely

documentation, enforcing a rigid timeframe for completing treatment summaries is not conducive to patient-centered care in all circumstances.

Recommendation: Revise this language to eliminate the 30-day requirement and instead align with organizational policies as required by their accrediting bodies.

5122-28-03 Performance Improvement

27. The hallmark of national accreditation is its specific attention to continuous performance improvement, which is detailed and well defined across operations, clinical services, and satisfaction. In (C), this rule now creates Appendix A, which includes 4 pages of additional, new criteria and expectations that a provider must conform to. Yet in (C)(1), the rule references following the accrediting bodies requirements for frequency and of data collection and analysis. Appendix A, may be applicable for organizations that are not accredited until such time as accreditation is required under 5119.36 of the Revised Code; however, for organizations that have national accreditation, it creates a double jeopardy scenario to require both conformance with the Appendix and compliance with national accreditation, adding unnecessary and costly duplication.

    Recommendations: Clarify in (C) that conformance with Appendix A is for organizations that have not attained national accreditation.

28. Appendix A uses the word “agency” which is not defined and an outdated term.

    Recommendation: Replace “agency” with “Provider organization” or “provider” throughout the document.

Thank you for considering our comments and feedback. We value our partnership and appreciate your commitment to incorporating stakeholder input into these critical rules affecting provider operations and, ultimately, patient care. We are available to meet for further discussion or can be contacted at your convenience at lampl@theohiocouncil.org