The Ohio Council
Of Behavioral Health & Family Services Providers

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**ODM Incident Management Draft Rules Package Comments**

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The Ohio Council of Behavioral Health & Family Services Providers (The Ohio Council) appreciates the opportunity to comment on the proposed incident management rule package, including OAC 5160-44-05, 5160-26-14, and 5160-59-09. We recognize the intent to align incident reporting and response expectations across Medicaid populations and delivery systems. When reviewed together, the proposed rules largely reflect a consistent framework. The comments below are offered to support clarity, regulatory alignment across state agencies, and effective implementation for providers operating within multiple oversight structures.

1. Paragraph (D)(2)(a)(ii)(f) in both 5160-26-14 and 5160-59-09 requires notification to the Ohio Department of Health (ODH) following certain incidents. While this reference is appropriate in OAC 5160-44-05, where ODH serves as the primary licensing and certification authority for nursing facilities, home health agencies, and many HCBS providers, it is too limited when applied to the MyCare and OhioRISE populations.

   Providers serving individuals enrolled in MyCare and OhioRISE may be licensed, certified, or otherwise regulated by state agencies other than ODH, including the Ohio Department of Behavioral Health (DBH), the Ohio Department of Children and Youth (DCY), and the Ohio Department of Developmental Disabilities (DODD), as well as professional licensure boards or accreditation bodies. Limiting the rule language to ODH alone may create uncertainty regarding appropriate reporting pathways and could result in duplicative, inconsistent, or misdirected notifications for providers operating under different regulatory authorities.

   Recommendation: Revise paragraph (D)(2)(a)(ii)(f) in 5160-26-14 and 5160-59-09 to require notification to ODH or, as applicable, to the state agency responsible for licensure or certification, the relevant professional licensure or certification board, or an accreditation body, when the incident involves a provider regulated by that entity.

2. Paragraph (E)(5) of 5160-44-05 and paragraph (D)(4) of both 5160-26-14 and 5160-59-09 address actions following the completion of an incident investigation, including determinations and corrective steps. While these provisions describe investigation outcomes and internal follow-up responsibilities, they do not explicitly require that providers involved in the individual's care receive a summary of investigation findings or be included in follow-up planning.

   Providers are responsible for implementing changes to service delivery as reflected in updated care plans, prevention plans, or safety plans following an incident. Without clear requirements to share investigation outcomes and include providers in these follow-up activities, there is a risk that investigative findings will not be fully translated into changes in service delivery or prevention strategies. This gap may limit providers' ability to support the individual and reduce the likelihood of recurrence.

Recommendation: Require that a summary of investigation findings be shared with the involved provider and that the provider be included, as appropriate, in updates to the individual's care plan, prevention plan, and crisis or safety plan.

3. The proposed incident management rules introduce an additional layer of incident notification and reporting for provider organizations that are already licensed or certified by state agencies including ODH, DBH, DCY, and DODD. These providers are already subject to established incident reporting, investigation, and corrective action requirements through their respective licensing or certification frameworks.

   As drafted, the rules require duplicative notification and oversight processes through the MCO or MCOP in addition to existing regulatory reporting obligations. This creates overlapping compliance requirements, increases administrative burden, and adds cost and staff time without clearly enhancing incident response, individual safety, or system accountability. For providers operating across multiple regulatory systems, these duplicative processes increase complexity and risk of inconsistent reporting timelines or expectations.

   In the context of ongoing efforts to improve government efficiency and reduce unnecessary administrative burden, the proposed approach may inadvertently undermine those goals by layering parallel oversight processes rather than leveraging existing regulatory structures.

   Recommendation: Consider streamlining incident notification requirements by eliminating or reducing required notification to the MCO or MCOP when a provider is already regulated by a state agency that requires incident reporting and investigation for the same event.

Thank you for considering our comments and recommendations. We welcome continued collaboration on this rule and would be glad to discuss these recommendations further. Please feel free to contact me at thrasher@theohiocouncil.org.