The Ohio Council
Of Behavioral Health & Family Services Providers

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

ODM Draft Rule 5160-44-05 Comments

Teresa Lampl, LISW-S

May 16, 2025

The Ohio Council of Behavioral Health & Family Services Providers (The Ohio Council) appreciates the opportunity to provide feedback on Draft Rule 5160-44-05 related to incident management standards for home and community-based services (HCBS), OhioRISE, Medicaid managed care organizations, and the Specialized Recovery Services (SRS) program. We recognize ODM's efforts to establish consistent and rigorous standards for incident reporting and protection of individuals. However, the use of the Home and Community Based Services (HCBS) Chapter 44 and building this rule on the foundation of HCBS waiver requirements which are designed to support and protect individuals that but for the waiver would likely be living in an institutional setting creates significant challenges when applied broadly to almost all individuals served by the Medicaid program. It creates conflicts with other state agency regulations, adds unnecessary regulatory burden for non-waiver programs and service providers, and is an overreach for persons not enrolled or seeking waiver services. We offer the following comments and recommended revisions to ensure provider compliance, align with clinical and regulatory best practices, and reduce unnecessary administrative burden.

Below are our specific comments on the OAC 5160-44-05.

1. The definition for "restrictive intervention" as drafted in paragraph (A)(9) includes low-level safety strategies such as "locking cabinets" or "limiting access to a desired item" as examples of restrictive interventions. These are widely used, non-coercive techniques in behavioral health and residential settings, often designed to promote safety, structure, or therapeutic boundaries. These practices, while appearing restrictive, are consistent with therapeutic structure and may be required by other entities (child welfare safety planning, juvenile court mandates, accrediting bodies, etc.) as part of an approved safety plan or individualized treatment plan. Classifying them as restrictive under ODM rules may conflict with other state agency definitions creating confusion and require incident-level documentation and justification even when those practices are permitted, encouraged, or required under other systems. Additionally, the definition in (A)(13) of "unauthorized restrictive intervention" on serves to further complicate the reading and does not clarify that restricting interventions may be used when part of an approved safety plan or treatment plan. Further, (A)(13)(a) and (b) are equally confusing as they appear to separate and repeat the definition of (A)(9) without context. Under HCBS rules, we appreciate these strategies may meet federal definitions as restrictive interventions, but this definition has far reaching implications in the general Medicaid population that may may lead to over-reporting of clinically appropriate practices, increase administrative burden without enhancing individual protections, and undermine trauma-informed care by discouraging structured environments.

   Recommendation: Simplify (A)(9) and (A)(13). Clarify that low-risk safety or therapeutic measures, when implemented without coercion and with informed consent as part of an individualized treatment plan or safety plan, are permitted and not considered "unauthorized restrictive interventions" requiring incident reports. Recognize the definition of "behavior

management" in OAC 5122-26-16 and OhioMHAS's Trauma-Informed Care Best Practices in Behavioral Health manual. These resources distinguish between restrictive interventions and supportive therapeutic strategies, and emphasize the use of individualized, trauma-informed approaches that prioritize safety, dignity, and collaboration.

2. Paragraph (A)(10) of the draft rule clearly relies on the HCBS waiver definitions of "seclusion" and "time-out," treating them as a single intervention whenever an individual is prevented from leaving a location. This definition conflicts with current regulatory standards under OhioMHAS Rule 5122-26-16, which defines seclusion in (C)(10) as the involuntary confinement of an individual in a space they are physically prevented from leaving, while time-out is separately defined in (C)(12) as a voluntary or supervised removal from a setting to support self-regulation. Time-out, in its standard therapeutic form, is not considered seclusion or a restrictive intervention unless physical coercion is used. As drafted, the ODM rule results in compliance challenges for providers who are subject to oversight by both ODM and OhioMHAS. Clear and consistent definitions are essential to support trauma-informed, least-restrictive care while ensuring patient safety and provider accountability.

   Recommendations: Revise paragraph (A)(10) to align with or at a minimum recognize existing definitions for "seclusion" and "time-out" as found in OAC 5122-26-16 and clarify incident reporting requirements accordingly, to support provider compliance and consistent cross system practice.

3. Language in (B)(1)(i) is an overreach and again may be appropriate in an HCBS waiver setting where individuals are at risk of hospitalization without receipt of services. However, individuals have a right to self-determination and freedom of movement without notice to healthcare providers or payers or even their family members. They are free to miss appointments, not respond to calls or attempts at outreach, and not provide notice to others of their location or intent to return even if it creates concern for family members, caregivers, or payers. While this language may apply to waiver settings or even residential settings, it will be hard to quantify when an individual is truly missing or even lost outside of those settings.

   Recommendation: Remove this subjective language in (B)(1)(i) or narrowly tailor it to those individuals living in an HCBS setting, nursing facility, or residential treatment setting.

4. (B)(2)(b) essentially results in state oversight and review of the development, updating, or review of a Health and Safety Action Plan (HSAP). As drafted this adds significant unnecessary governmental oversight that has the likelihood to interfere with clinical decision making and team based care planning and may present as prior authorization of decision making in all settings and circumstances. Treating every review, update, or development of the HSAP occurrences as reportable incidents may undermine trust with families and stigmatize engagement, particularly for those from marginalized or system-involved communities and fails to respect the clinical decision making process or established individual or child and family care teams that exist in other ODM rules. This costly overreach will result in unnecessary reporting, detracting from attention to more serious or emergent risks.

   Recommendation: Revise (B)(2)(b) to require reporting only behavior, action, or inaction that poses a documented, imminent threat to the individual's health or welfare, and situations where individual or family behavior results in escalated risk or the need for protective intervention.

5. Requiring reporting of all suicide attempts is stigmatizing, unnecessary and inconsistent with current OhioMHAS incident reporting rules in 5122-26-13. For individuals with serious mental health conditions (i.e. borderline personality disorder, PTSD, etc.), repeated self-harming behavior may be recognized as part of their diagnosis and already addressed through a documented treatment or safety plan. Automatically requiring incident reports for each occurrence, even when clinically anticipated and managed, will lead to overreporting, increased unnecessary administrative burden, and unintentionally stigmatize the individual.

   Recommendation: Limit reporting of suicide attempts to only those incidents that are not part of an existing treatment or safety plan.

6. The incident reporting requirements outlined in Paragraph D are complex and potentially duplicative. The draft rule appears to be designed to serve as a streamlining effort, however here, it then here imposes exceptions for different reporting thresholds and timelines across multiple Medicaid programs or other existing ODM rules. For example, certain incident types are only reportable under specific programs or have different dollar thresholds for reporting based on program enrollment, such as the $500 misappropriation threshold in OhioRISE. Additionally, reporting timeframes vary based on the program and type of incident, with critical incidents requiring entry into the system within one business day, while others allow up to three business days. This inconsistent structure adds unnecessary complexity and creates confusion for providers who often serve individuals subject to multiple ODM rule chapters. This complexity increases the risk of misreporting, delays, or inadvertent noncompliance. These administrative demands divert critical time and attention away from direct client engagement, particularly for small providers or care coordinators managing high caseloads. Standardizing thresholds and timelines would streamline provider workflows and ensure faster response to actual risk.

   Recommendation: Standardize reporting requirements and thresholds across all relevant ODM programs and with cross-system state agencies with similar rules and reporting structures to provide unified guidance and definitions to reduce duplication and support provider understanding and implementation.

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 lampl@theohiocouncil.org.