CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Aging (ODA)

Regulation/Package Title: Adult Day Services

Rule Number(s): Rules 173-3-06.1 and 173-39-02.1 of the Administrative Code
Date: April 24, 2013 (Revised April 26, 2013 and May 30, 2013)

Rule Type:

X New (both rules)
_ Amended
X 5-Year Review (both rules)
X Rescinded (both rules)

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Business Impact Analysis

Regulatory Intent

1. Please briefly describe the draft regulation in plain language.
Please include the key provisions of the regulation as well as any proposed amendments.

INTRODUCTION

Adult Day Services are Well-Established

For more than 20 years, adult day services (ADS) centers have been providing care in supervised community settings for men and women of all ages with partial disabilities and dementia. Centers provide opportunities for adults who are socially isolated to find friends and learn skills. They also enable individuals to obtain the care they need without being forced to live in institutions. They are a cost-effective, community-based service option in the long-term care continuum, and help keep individuals at home, with family and friends, for as long as possible.

ADS programs potentially can delay or prevent nursing home placement in large part by supporting informal caregiving and offering needed respite to caregivers. More than seven million Americans provide 120 million hours of care to about 4.2 million elderly persons with functional limitations each week. Research has found that caregivers who experience stress and burden are more likely to institutionalize relatives suffering from dementia.[1]

Ohio is One Level Less Regulated Than Licensure States

Many states license ADS centers in a manner similar to how states license nursing facilities. Ohio does not have that level of regulation. Instead, an ADS center is free to go into business without a license. However, if the ADS provider wants to do business with ODA, the provider must comply with ODA's regulations for the ADS that they provide to consumers who are enrolled in ODA's programs.

2 Routes for Doing Business with ODA

The state will only reimburse a provider for providing ADS to consumers who are enrolled in the Choices or PASSPORT Programs or the Alzheimer's Respite or Older Americans Act programs.

A provider who provides ADS to consumers who are enrolled in the Choices or PASSPORT Programs *must become certified* by ODA in order for ODA to reimburse the provider for its expenses. In order to become certified, the provider must comply with the conditions of participation listed in rule 173-39-02 of the Administrative Code. One of the conditions for ADS providers is to comply with the specific requirements for ADS providers under rule 173-39-02.1 of the Administrative Code.

A provider who provides ADS to consumers who are enrolled in the Alzheimer's Respite or Older Americans Act Programs *must enter into a provider agreement* with an area agency on aging in order for the programs to pay the providers for their expenses. Every provider agreement must contain the mandatory clauses in rule 173-3-06 of the Administrative Code (which are very similar to the conditions of participation in rule 173-39-02 of the Administrative Code). One of the mandatory clauses for ADS providers is to comply with the specific requirements for ADS providers under rule 173-3-06.1 of the Administrative Code.

[1] Ohio Department of Aging. "Aging Connection." © September, 2010.

Many providers are reimbursed for the ADS they provide to consumers by many sources, including the aforementioned 4 ODA-administered programs. Thus, many providers are doing business with ODA on the basis of both *certification* and *a provider agreement.* (ODA will illustrate this in ODA's response to #14b.)

Budget
H.B.59 is proposing to increase the maximum reimbursement rates for ADS that providers provide to consumers who are enrolled in the PASSPORT and Choices Programs. H.B.59 is also proposing to increase by $100,000 per year the funds appropriated to the Alzheimer's Respite Program which, in part, funds ADS that providers provide to consumers who are enrolled in that program. While, the occasion for proposing to adopt new rules is not the proposed funding increases in H.B.59, ODA's proposal coincides with H.B.59's proposed increases.

UNIFORM RULES
As ODA stated in the introduction, many ADS providers serve consumers who are enrolled in programs that both of ODA's rules regulate. Furthermore, the largest revenue sources for providers comes from programs that both of ODA's rules regulate. (See ODA's response to #14b for illustrations on the degree to which ADS providers serve consumers who are enrolled in various government programs, which, in turn, means that various sets of rules regulate the providers.)

Therefore, ODA proposes to reduce the burden associated with complying with ODA's two sets of ADS regulations by adopting new language for rules 173-3-06.1 and 173-39-02.1 of the Administrative Code that is uniform in format, terminology, and requirements. To achieve uniform language between the rules, ODA proposes to make the following changes:

- **Outline:** Paragraph (B)(1) of one rule would match paragraph (B)(1) of the other rule and paragraph (B)(2) of one rule would match paragraph (B)(2) of the other rule, and so on.

- **Transportation:** Both rules would give the provider an exception from the responsibility to provide transportation if the consumer or caregiver arranges for personal transportation from a source other than the ADS provider. Currently, only rule 173-3-06.1 of the Administrative Code allows this exception. As ODA states in ODA's response to #14b, unifying the transportation exception in both rules would result reduce the adverse impact.

- **Caregivers:** Both rules would use the term "caregiver." Currently, rule 173-3-06.1 of the Administrative Code uses the term "family caregiver."[2]

- **Initial Assessments:**

[2] Section 302 of the Older Americans Act, as amended in 2006, defines "family caregiver" to include family members and non-family members, which makes adding the word "family" to the term misleading.

- Providers would only be required to include *major* life events in the social profile. Currently, rule 173-39-02.1 of the Administrative Code requires including life events (in general) in the social profile, which applied literally, would be excessive. As ODA states in ODA's response to #14b, only requiring providers to include *major* life events in a consumer's social profile would reduce the adverse impact.

- Both rules would state that a provider is not responsible for conducting an initial assessment—relief from an adverse impact—if the consumer receives case management and was recently assessed by the case manager. For a consumer who receives ADS that funded by the Older Americans Act, the consumer would only receive case management if the consumer receives care coordination. Thus, in rule 173-3-06.1 of the Administrative Code, but not rule 173-39-02.1 of the Administrative Code, ODA states places the language related to a case manager's assessment in the conditional. (*i.e.*, "*If* a case manager assesses....")

- **Activity Plans:** Both rules would use "activity plan." Currently, rule 173-39-02.1 of the Administrative Code uses "individualized care plan."

- **Non-Physician Professionals:** Both rules would use the same language regarding employing physician assistants, clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to provide health assessments, activity plans, and plans of treatment. Both rules also use the same language regarding obtaining health assessments, activity plans, and plans of treatment from these professionals when they do not work for the provider. (See below under "**PLANS OF TREATMENT**" for information on the plan-of-treatment language.) Both rules would also use the same language regarding employing, or obtaining the services of, physician assistants, clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives for interdisciplinary care conferences. As ODA states in ODA's response to #14b, unifying the language would reduce the adverse impact.

- **Lunch:** Both rules would call food "lunch" and "snacks" and call the times to eat "lunchtime" and "snacktime." Currently, rule 173-39-02.1 of the Administrative Code uses "lunchtime meal" and rule 173-3-06.1 of the Administrative Code uses "mealtime."

- **Separate Space and Staff:** Both rules would use the same language when requiring ADS centers to have a separate, identifiable space and staff during all hours that they provide ADS if the center in which they provide ADS is also used for other services or programs. Currently, rule 173-3-06.1 of the Administrative Code requires "a separate, identifiable space for ADS staff and ADS activities..." while rule 173-39-02.1 of the Administrative Code requires "a separate, identifiable space and staff...."

- **Activities Directors:** Both rules would define each position as "activities director." Currently, rule 173-3-06.1 of the Administrative Code defines the term as "Activity staff person who directs consumer activities." See below under "**ACTIVITIES DIRECTORS**" for information on a specific area of uniformity.

PLANS OF TREATMENT

Ordering plans of treatment includes ordering therapeutic diets, nursing services, nutrition consultations, physical therapy, or speech therapy. Although Chapter 4730 of the Revised Code would allow a physician assistant to do so, and Chapter 4723 of the Revised Code would allow clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to do so, ODA's current ADS rules only allow *physicians* to order plans of treatment.

Therefore, ODA is proposing to amend rules 173-3-06.1 and 173-39-02.1 of the Administrative Code to allow physician assistants, clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to order plans of treatment for consumers receiving ADS.

As ODA restates in its response to #14b, this proposed new language would not create an adverse impact for any ADS provider. On the contrary, if an ADS provider's business model involves employing, or contracting with, medical professionals to develop plans of treatment in house, the proposed new language would allow the provider to employ, or contract with, physician assistants, clinical nurse specialists, certified nurse practitioners, or certified nurse-midwives to instead of physicians. Allowing ADS providers to employ, or contract with non-physician medical professionals should save the ADS providers funds. The Bureau of Labor Statistics reports that the average mean wages for Ohio-based physician assistants, nurse practitioners, and nurse midwives is 49%, 48%, and 47% (respectively) of the wages of Ohio-based physicians.[3]

If an ADS provider's business model does not involve employing, or contracting with, medical professionals to develop plans of treatment in house, the consumers attending the ADS center would need to see a medical professional to obtain a plan of treatment. Therefore, the proposed new language would not create, nor reduce, an adverse impact upon such an ADS provider with this business model. However, for the physicians' offices that examine the consumers who attend such ADS centers, the proposed new language could lower the cost of doing business by allowing physician assistants in those offices to develop the plans of treatment.

ELECTRONIC RECORDS

[3] Bureau of Labor Statistics. "Occupational Employment Statistics: Occupational Employment and Wages." © May, 2012. (BLS reported that, in May, 2012, Ohio physicians (29-1069) received an annual mean wage of $184,210 while Ohio physician assistants (29-1071) received an annual mean wage of $89,800, Ohio nurse practitioners (29-1171) received an annual mean wage of $87,990, and Ohio nurse midwives (29-1161) received an annual mean wage of $86,560.)

ODA is proposing to amend rules 173-3-06.1 and 173-39-02.1 of the Administrative Code to explicitly permit providers to retain records electronically instead of on paper.

ADEQUATE SQUARE FOOTAGE AND TOILETS

In order to engage in business serving consumers who are enrolled in ODA-administered programs, the current versions of rules 173-3-06.1 and 173-39-02.1 of the Administrative Code require each ADS center to meet an adequate-space requirement of 60ft^2 per consumer. As ODA mentions in #14b, ODA's 60ft^2 requirement is modest in light of the average square footage for ADS centers, which is 194ft^2 per consumer.[4]

For a provider that provides ADS to consumers who are enrolled in ODA's programs and also to other individuals, ODA is proposing to clarify that, *regardless of the funding source for a consumer's ADS,* an ADS center must have at least 60ft^2 of space per consumer, excluding hallways, offices, rest rooms, and storage areas.

- Example 1: If an ADS center wants to serve up to 20 consumers at any given time (10 of which would be enrolled in ODA-administered programs), the ADS center would need to multiply the total number of consumers served (not the total number of consumers who are enrolled in ODA-administered programs) by 60 to see how much square footage it must have to handle that consumer load. In doing so, it would find that the ADS center that serves 20 consumers would need 1,200 square feet of space.

- Example 2: If an ADS center has 1,200 square feet of space and wants to serve consumers who are enrolled in ODA-administered programs, it would need to divide its square footage by 60 to see how many consumers it could serve. In doing so, it would find that the ADS center could serve up to 20 consumers at a time.

As ODA will repeat in #14b, because the average ADS center has 194ft^2 per consumer, and because ODA's current rules *already* require 60ft^2 per consumer, every provider that is presently engaged in business serving consumers who are enrolled in ODA's programs should see no adverse impacts from the proposed new language on adequate square footage. The new language only clarifies the adequate-space requirement already in place.

Additionally, by following the same logic that ODA stated regarding adequate square footage, ODA is proposing to clarify the requirement already in place related to the number of working toilets. ODA is proposing to clarify that an ADS center must have at least 1 working toilet for every 10 consumers that it serves, *regardless of the funding source for a consumer's ADS.* As previously stated, an adequate number of toilets is more critical for consumers who receive ADS than the general population

[4] MetLife Mature Market Institute, The Ohio State University College of Social Work, National Adult Day Services Association. "The MetLife National Study of Adult Day Services." © October, 2010. *Pg.*, 12.

because 45% of the consumers who receive ADS require assistance with toileting.[5] Providing assistance with toileting implies lengthier times on toilets, which implies a reduced availability of any given toilet, which indicates the need for an adequate supply of working toilets.

As ODA will repeat in #14b, because ODA's current rules *already* require one working toilet for every 10 consumers, every provider that is presently engaged in business serving consumers who are enrolled in ODA's programs should see no adverse impacts from the proposed new language on adequate toilets. The new language only clarifies the requirement already in place regarding the number of working toilets.

ACTIVITIES DIRECTORS

In order to engage in business serving consumers who are enrolled in ODA-administered programs, the current versions of rules 173-3-06.1 and 173-39-02.1 of the Administrative Code require each provider to hire an activities director that meets specific qualifications that include a degree in recreational therapy *or a related degree* or 2 years of experience. However, the two rules are not uniform on every way in which a person may qualify for the activities-director position.

As of May 30, 2013, ODA has relinquished its present initiative to adopt uniform qualifications for activities directors.

NON-SUBSTANTIVE

ODA is also proposing to non-substantively amend the rules in order to:

- Update the definitions of "adult day service" in both rules to make them uniform to one other and to better approximate the core service definition promoted by CMS,[6] which is not substantially different than ODA's current definitions.

- Update the citations of specific references to the Code of Federal Regulations in both rules pursuant to section 121.75 of the Revised Code. (*e.g.*, "July 1, 2012 edition.")[7]

- Require providers to state how specific goals, objectives, and planned interventions listed in each consumer's activity plan *meet* the goals of the activity plan. The current versions of the rule require the provider to state how specific goals, objectives, and planned interventions *enable* the goals of the activity plan.

[5] MetLife Mature Market Institute, The Ohio State University College of Social Work, National Adult Day Services Association. "The MetLife National Study of Adult Day Services." © October, 2010. *Pg.*, 23.
[6] Centers for Medicare & Medicaid Services. "Instructions, Technical Guide and Review Criteria: Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]." © January, 2008. *Pg.*, 150.
[7] Section 121.75 of the Revised Code also requires ODA to state in rules the date of the last amendment to the any federal act or code cited in a rule.

- Replace the use of "direct-care staff" with "personal care staff." Eliminating the use of "direct care" in this rule may prevent confusion with the definition of "direct care" in rule 173-9-01 of the Administrative Code (regarding criminal records checks), which defines office work as direct care, even if the staff member has no in-person contact with consumers. Eliminating the use of "direct care" in this rule may also prevent confusion if Ohio establishes its proposed credentialing for direct-care staff and the definition of "direct care" for that project would differ from the use in this rule.

2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

- Sections 173.391 and 173.392 of the Revised Code require ODA to adopt rules to establish requirements and to evaluate if the services provided by providers are done in a quality manner that is advantageous to the consumers of the services.

- Sections 173.04 and 173.40 of the Revised Code authorize ODA adopt rules for the Alzheimer's Respite and PASSPORT Programs.

- Sections 173.01 and 173.02 of the Revised Code give ODA general authority to adopt rules to regulate services provided through programs that it administers.

3. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
If yes, please briefly explain the source and substance of the federal requirement.

For rule 173-3-06.1 of the Administrative Code: Section 305(a)(1)(C) of the Older Americans Act of 1965, 79 Stat. 210, 42 U.S.C. 3001, as amended in 2006, and 45 C.F.R. 1321.11 (10-01-2012 edition) requires ODA to adopt policies governing all aspects of the Older Americans Act Programs, including for services delivered by providers who enter into contracts with ODA or ODA's designees to provide ADS.

For rule 173-39-02.1 of the Administrative Code: In Ohio's application to the Centers for Medicare and Medicaid Services (CMS) for the waiver to authorize the PASSPORT and Choices Programs, Ohio indicated that ODA adopted a rule on ADS and cited the rules by number. Because CMS authorized the PASSPORT and Choices Programs in Ohio by approving the application, ODA is responsible for maintaining the rule 173-39-02.1 of the Administrative Code.

4. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

ODA's proposed amendments to ODA's two ADS rules are not the result of any federal requirement.

5. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

There are at least 3 public purposes:

1. Both rules exist to comply with the state laws that ODA listed in #2.

2. Rule 173-3-06.1 of the Administrative Code exists to comply with the federal laws that ODA listed in #3.

3. [Speaking to amendments] Both rules exist to reduce the regulatory burden where possible by (1) making uniform regulations, including uniform transportation exceptions; (2) accepting plans of treatment from non-physician professionals that have such duties in their scopes of practice; and, (3) by allowing electronic record-keeping.

6. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

ODA (and ODA's designees) will monitor the providers for compliance.

Development of the Regulation

7. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.
If applicable, please include the date and medium by which the stakeholders were initially contacted.

ODA contacted a significant number of stakeholders on multiple occasions to seek input on this 2-rule project.

On March 15, 2013, ODA emailed a representative for the Ohio Physician Assistants Association. In the past, he had approached ODA to request amendments to ODA's rules that require physicians to perform services that section 4730.09 of the Revised Code also allows physicians assistants to perform. ODA informed OPAA that ODA is currently considering amendments to our two rules for ADS. One rule (173-39-02.1) regulates ADS for our PASSPORT and Choices Programs. The other rule (173-3-06.1) regulates ADS for our non-Medicaid programs like Alzheimer's Respite and Older Americans Act Programs. ODA requested OPAA's input on the matter. On March 19, 2013, ODA followed up on the email to OPAA and OPAA stated they were reviewing the issue and would soon respond.

On March 19, 2013, ODA emailed the following providers of ADS: Senior Resource Connection, Wood County Council on Aging, the Licking County Aging Program (exec. dir. is also president of the Ohio Senior Center Assn.), Guernsey County Senior Citizens Center, Inc., Heritage Day Health, and Sycamore Senior Center. On the same day, ODA also emailed the following associations that represent providers who provide ADS: Midwest Care Alliance and National Church Residences.

In the email, ODA stated that it is reviewing its two ADS rules for possible amendments and indicated that those rules are:

- Rule 173-3-06.1 of the Administrative Code, which regulates ADS for Alzheimer's Respite and Older Americans Acts Programs

- Rule 173-39-02.1 of the Administrative Code, which regulates ADS for the PASSPORT Program (and Choices Program for parts of the state where that pilot project operates).

In the email, ODA also indicated that the review is not directly connected to the proposed 30% rate increase in the pending state operating budget. ODA's goal is to review the rules and have any amended rules adopted on July 1, 2013 to coincide with the renewal of the PASSPORT Medicaid waiver. This date, however, would also coincide with the beginning of the state's biennial budget.

ODA stated that it was open to any input the providers (or provider association) would like to provide on these rules, including requests for amendments and information on how the rules may adversely impact your business. So far, ODA has identified the following items as potential items to amend:

- Because many ADS providers serve consumers who are enrolled in programs regulated by both rules, it would help businesses for the rules to be as identical as possible—in terminology, format, and requirements.

- The rule currently only allows physicians to order plans of treatment for meals with therapeutic diets, nursing services, nutrition consultations, physical therapy, or speech therapy. ODA is considering amending the rule to let physician assistants, clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to do this, too.

- ODA intends to explicitly state that providers may retain records electronically instead of on paper.

- Clarify that the rules require that the ADS centers have at least 60ft^2 of space per consumer, excluding hallways, offices, rest rooms, and storage areas. Before engaging in business serving consumers who are enrolled in ODA-administered programs, the ADS center must already meet the 60ft^2 requirement. An ADS center that bases its calculations on square footage per consumer enrolled in ODA-administered programs may end up having insufficient size to properly serve the consumers.

- ODA wants to combine the required qualifications for activities directors so that they must have a degree in recreational therapy *and* (not *or*) at least two years of experience as an activities director or activity coordinator.[8]

In the email, ODA also stated that, in addition to supplying any of your own requests for amendments, please feel free to comment on the potential amendments that ODA has listed above.

Lastly, ODA requested that each provider supply a count of the number of consumers to whom they serve ADS to by program (PASSPORT, Choices, Older Americans Act, and Alzheimer's Respite).

On March 20, 2013, ODA sent an email update to the providers and provider associations listed above to encourage them to email to ODA any input on the rules they would like to provide on the rule before 3:00PM on March 21, 2013 so that ODA would have time to review the input before submitting rule drafts (and this business impact analysis) to the Common-Sense Initiative Office on March 25, 2013.

On April 11, 2013, ODA made a presentation to a monthly meeting of the Ohio Association of Senior Centers about the Common-Sense Initiative and ODA's pending rule projects, including this rule project. (ODA had previously emailed OASC about this rule project.)

[8] As ODA notes in ODA's responses to #8 and #10, the input of providers convinced ODA to choose an alternate strategy for amending the required qualifications for activity directors.

On April 15, 2013, ODA contacted the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board with a request for technical assistance regarding requiring occupational therapy and physical therapy *degrees* or *licenses.*

On April 17, 2013, ODA followed-up with the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board.

Additionally, ODA posted the rule proposals and business impact analysis on its website to seek public comments. At the same time, ODA distributed an email to subscribers of our email notification service to announce that ODA had placed the rules and the business impact analysis on our website to seek public comments.

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

On March 19, 2013, the Ohio Association of Senior Centers indicated the following:

- They liked the idea that the rules would be as identical as possible in terminology, format, and requirements.
- They believe it would be alright for PAs and certain nurses to order plans of treatment.
- They believe providers already use electronic records.
- They like the idea of clarifying the requirement for 60ft^2 of space per consumer, *regardless of the funding source for the consumer's care*.
- They like the idea of combining the required qualifications for activities directors.

Additionally, at the April 11, 2013 monthly meeting of the Ohio Association of Senior Centers, none of the executive directors of senior centers raised issues with this rule project although they raised issues with other rule projects.

On March 21, 2013, the Ohio Physician Assistants Association responded that the language that would allow PAs and certain nurses to order plans of treatment looked good.

On March 21, 2013, Senior Resource Connection provided the following response: "I am cool with all the proposed changes nothing jumps out now."

On March 21, 2013, the Wood County Committee on Aging, Inc. (WCCOA) emailed that they have not yet established themselves as ADS providers and are in the planning stages with a goal of opening the service in the first quarter of 2014. WCCOA asked ODA to define the parameters of "or related degree" when referring

to the required qualifications for activities directors. On March 22, 2013, ODA informed WCCOA that ODA is considering replacing "or related degree" with a concrete list of degrees instead of defining the term "related."

On March 21, 2013, National Church Residences wrote the following to ODA:

Thank you for asking for National Church Residence's early input on proposed new Ohio Department of Aging Rules:

- National Church Residences understands the desire to make ADS and PASSPORT rules as identical as possible in order to help businesses navigate both sets of rules. The only concern we may have with proposed rules surrounding these programs would be that proposed rules not complicate programs that are already clearly outlined in ODA rule, such as the Alzheimer's Respite program. In order to provide more specific comments, we would need to review proposed changes.

- National Church Residences is supportive of ODA is amending the rule to let physician assistants, clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to order plans of treatment for meals with therapeutic diets, nursing services, nutrition consultations, physical therapy, or speech therapy. This change would allow us to more efficiently and effectively care for our clients.

- National Church Residences supports explicitly stating in rule that providers may retain records electronically instead of on paper.

- National Church Residences supports clarifying the requirement of 60-square-feet of space per client that this space requirement calculation is based on the total number of clients served at a given time, not just those enrolled in an ODA-administered program.

- National Church Residences has concerns regarding combining the required qualifications for activities directors so that they must have a degree in recreational therapy *and* (not *or*) at least two years of experience as an activity director or activity coordinator. Like ODA, National Church Residences wants to ensure ADS clients participate in high quality activities that are appropriate for their care and individual needs. If the rule were changed, National Church Residences could be forced to terminate employment of several activities directors, and incur an additional $92,000 annually. As an alternative to the proposed change, National Church Residences would support a requirement that a degreed recreational therapist be engaged to consult with activities staff to plan, design, and help implement activities to ensure appropriate activities for our individual clients. We would welcome the opportunity to discuss this proposed rule further.

On April 17, 2013, ODA asked National Church Residences to explain the method by which NCR's current activities directors qualify for their positions.

On April 18, 2013, NCR responded by saying, "Thanks for asking. The majority of our activities directors qualify under the having two years experience as an activities director, coordinator, or related position prong of the rule. Further, we look for activities directors with that experience within the last 5 years." ODA immediately thanked them for the information and said it would take this into consideration as it finalized its proposed new requirements for activities directors.

On March 21, 2013, Midwest Care Alliance emailed ODA with the following:

> We have some concerns regarding combining the required qualifications for activities directors so that they must have a degree in recreational therapy ***and*** (not *or*) at least two years…… It would be helpful to use the term "or" in this sentence. Without doing so increases the cost and need to remove current staff at several of our members facilities then hire others to replace and at a higher cost than current. This would be a difficult cost to absorb in the current reimbursement market. The 60-sqft could also be a concern for some of our sites. As we look at other states we find sq ft requirements that range from 35 – 48 sq. ft. Otherwise this requires some of our members to look to lease other space or reduce the number of individuals cared for at some current facilities, reducing the access to care. We also find a number of benefits which will be addressed as well.

On March 21, 2013, ODA thanked MCA for submitting early input into ODA's rule proposals. On April 18, 2013, ODA informed MCA that ODA considered the issues it raised and will add "grandfathering" language for those who qualify on the basis of experience alone. Because the average square footage is 194 square feet, ODA feels confident that reinforcing its 60ft^2 requirement is modest

On April 18, 2013, the Occupational Therapy, Physical Therapy, and Athletic Trainers Board responded to ODA's request for technical information by stating that it is more appropriate for ODA to require occupational therapists and physical therapists to hold current *licenses* than *degrees* in occupational therapy or physical therapy.

In response to multiple comments that ODA received during the public-comment period ODA relinquished its present effort to adopt uniform requirements for activities directors in the rules.

In response to a comment that ODA received from United Seniors of Athens County (USAC) during the public-comment period, ODA added clarifying language to proposed new rule 173-3-06.1 of the Administrative Code. Rule 173-3-06.1 of the Administrative Code is the rule that regulates ADS when ADS are provided to consumers through programs funded by the Older Americans Act. USAC commented that there is no requirement for case management for consumers who receive ADS funded by the Older Americans Act. USAC seems concerned that ODA is proposing a new adverse impact by referring to case management in the aforementioned rule. (Rule 173-39-02.1 of the Administrative Code regulates ADS when the service is provided to consumers through the PASSPORT or Choices Programs, which are Medicaid-funded programs. Medicaid-funded programs require case management. USAC's comment does not pertain to rule for Medicaid-funded ADS.)

ODA believes that the act of referring to case management in rule 173-3-06.1 of the Administrative Code needs no fix. Here are 4 reasons why ODA is not creating an adverse impact by referring to case management:

1. Case management already exists. The current rule says area agencies on aging (AAAs) provide case management, which is not necessarily correct. AAAs may contract outside entities (*e.g.*, local councils on aging) to provide case management. ODA's replacement of "AAA" with "case manager" reflects a technical correction, not a new requirement. (Reason #4 below shows that correcting the terminology can reduce an adverse impact.)

2. Federal law, not ODA, establishes case management for consumers who receive services funded by the Older Americans Act. Section 306(a)(8) of the Act requires area plans to include case management services. Section 102(a)(11) of the Act defines a case management service to include care coordination. The Act allows case management (care coordination) to be different in each of Ohio's 12 planning and service areas (PSAs) because the Act requires AAAs to set the parameters for case management (care coordination) in their area plans. In a given PSA, none, some, or all consumers who receive ADS funded by the Older Americans Act may also receive case management funded by the Older Americans Act. (As noted under "ODA may be able to quantify the adverse impact," one AAA reported that 100% of consumers who receive ADS in its PSA also receive case management as part of care coordination.) Case management is established even if USAC may not provide ADS to case-managed consumers.

3. Both the current and the proposed new versions of the 2 ADS rules relieve providers from the adverse impact of initially assessing consumers *if* case managers recently assessed the same consumers. Therefore, to refer to case managers' assessments is to refer to means for relief from an adverse impact.

4. ODA is proposing to make it easier to do business in Ohio. ODA's logic follows:

    a. Providers who serve a population of consumers who have enrolled in various state-administered programs that fund ADS may need to regularly review each program's rules in order to discern how to lawfully provide ADS to consumers based upon the program in which each consumer has enrolled. The existence of variances between each program's rules creates an administrative burden upon providers. An administrative burden is an adverse impact.

    b. To significantly reduce variances, ODA is proposing to rescind its two ADS rules and adopt 2 new ADS rules in their stead. The 2 new ADS rules would have identical terminology (*e.g.*, "case manager's assessment") and identical outlines (*e.g.*, "(B)(2)" = "(B)(2)," "(B)(3)" = "(B)(3)," *etc.*). ODA loosely calls this strategy for reducing unnecessary variances "unifying" rule language.

c. The requirements for case managers' assessments *vs.*, providers' initial assessments in the 2 ADS rules are substantially similar. However, the language that presents the requirements varies, as follows: (1) As mentioned in reason #1 above, rule 173-3-06.1 of the Administrative Code uses "AAA" while rule 173-39-02.1 of the Administrative Code uses "case manager"; and, (2) the current version of rule 173-3-06.1 of the Administrative Code combined language that refers to the 2 parties responsible for assessments into 1 paragraph, while the current version of rule 173-39-02.1 of the Administrative Code refers to each party separate paragraphs.

d. ODA is proposing to eliminate apparent variances between the 2 ADS rules by: (1) using identical terminology, to the extent possible; and, (2) using identical rule outlines, to the extent possible, which involves dividing references to the 2 parties responsible for assessments under rule 173-3-06.1 of the Administrative Code into 2 separate paragraphs that align with 2 counterpart-paragraphs in rule 173-39-02.1 of the Administrative Code.

Nevertheless, ODA proposes to augment the manner in which it is proposing to refer to case management in rule 173-3-06.1 of the Administrative Code. In ODA's earlier attempt to unify rule language (*i.e.*, the version that ODA posted on its website for a public-comment period), ODA omitted the words "care coordination" in rule 173-3-06.1 of the Administrative Code because the words did not appear in rule 173-39-02.1 of the Administrative Code. Although consumers who receive care coordination also receive case management, there is no requirement for every consumer who receives services funded by the Older Americans Act to also receive care coordination or case management. ODA's omission of a conditional clause and of "care coordination" in the earlier version of the proposed new rule 173-3-06.1 of the Administrative Code was the probable cause for USAC's comment.

Thus, ODA is now proposing language that would refer to case management in rule 173-3-06.1 of the Administrative Code, as follows: (1) in connection to care coordination; (2) as defined by the Older Americans Act; and, (3) with additional emphasis that case management relieves an ADS provider from the requirement to conduct an initial assessment of the consumer.

On May 28, 2013, ODA contacted AAA5 (Mansfield) to ask for a sample correlation between consumers who receive both ADS and case management that are funded by the Older Americans Act. AAA5 reported that 100% of consumers in PSA5 who receive ADS funded by the Older Americans Act also receive case management (care coordination) funded by the Older Americans Act. In PSA5, case management reduces adverse impact upon all ADS providers. ODA has not conducted a statewide analysis, but the prominence of case management in PSA5 may indicate prominence statewide.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

ODA reviewed its proposals regarding adequate-space requirements, adequate-toilet requirements, and unified rule language in light of statistics in the MetLife National Study of Adult Day Services.[9]

ODA estimated the potential regulatory relief that would come from allowing non-physician assistants to supply plans of treatment by using statistics from the Bureau of Labor Statistics.[10]

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

Most of the providers and associations that ODA polled seemed to view all the proposed amendments favorably when polled for feedback. However, one provider and two organizations raised concerns about ODA's proposal to amend the rules to restate the required qualifications for activities directors. ODA wrote to these organizations, as noted under #8, asking for early input on ODA's proposal to combine the two ways to qualify to be an activities director (*i.e.*, a degree *or* job experience) into one way to qualify (*i.e.*, a degree *and* job experience).

NCR and MCA stated that the ADS centers they represent would need to fire certain current activities directors if ODA combined the two ways to qualify into one way to qualify. To avoid the loss of currently-held jobs, ODA added a "grandfather clause" to the list of qualifications that states that a way to qualify for the position is to have had two years of experience if the provider hired the person into the activities-director position before July 1, 2013.

Based upon ODA's experience with attorneys asking ODA to define "or related" and the similar comment from WCCOA, ODA decided to delete the words "or related" from the rule and, instead, list any related profession in the rule.

ODA changed an earlier proposal to consider a *degree* in occupational therapy or physical therapy as a way to qualify to be an activities director. Based upon the input of the Occupational Therapy, Physical Therapy, and Athletic Trainers Board, ODA is now proposing to consider *licensure* in occupational therapy or physical therapy as a way to qualify to be an activities director.

After receiving multiple comments during ODA's public-comment period regarding the ODA's proposal to adopt new requirements for activities directors, ODA has relinquished its previous effort to adopt uniform requirements for activities directors.

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[9] MetLife Mature Market Institute, The Ohio State University College of Social Work, National Adult Day Services Association. "The MetLife National Study of Adult Day Services." © October, 2010.

[10] Bureau of Labor Statistics. "Occupational Employment Statistics: Occupational Employment and Wages." © May, 2012.

11. Did the Agency specifically consider a performance-based regulation? Please explain.
Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

The state is considering performance-based regulations. On February 21, 2013, the Governor's Office of Health Transformation announced that Ohio received a federal grant to advance health care payment innovation that would "accelerate the state's work to improve overall health system performance through payment innovation and service delivery improvements...to develop and implement evidence-based health care strategies that improve the health of individuals rather than simply treat disease."[11] However, the review deadline for this rule will precede the outcomes of the state's efforts to develop and implement the evidence-based strategies. Therefore, the present review of rule 173-39-02.1 of the Administrative Code does not implement performance-based regulations.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

ODA reviewed the Ohio Administrative Code. Sections 173.391 and 173.392 of the Revised Code give ODA the authority to develop requirements for providers who provide services to consumers who are enrolled in ODA-administered programs. No other state agency has adopted such rules.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

ODA posts all proposed and currently-effective rules on its website. (http://aging.ohio.gov/information/rules/default.aspx) Before a rule takes effect, ODA posts it on its website and sends an email to any subscriber of our rule notification service.

ODA will work with its designees (PASSPORT administrative agencies) to ensure that the regulation is applied uniformly.

ODA and its designees will also monitor the providers for compliance. Rule 173-39-02 of the Administrative Code states that a condition of being an ODA-certified provider is allowing ODA or the PASSPORT administrative agency to monitor the provider.

[11] Governor's Office of Health Transformation. "Ohio Receives Federal Grant to Advance Health Care Payment Innovation." Press release. © February 21, 2013.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

At the end of December 2012, ODA's PASSPORT was reimbursing 99 providers for the ADS they provided to 2,420 consumers.

At the end of December 2012, ODA's Choices was reimbursing 10 providers for the ADS they provided to 17 consumers.

At the end of December 2012, ODA's Older Americans Act Programs was reimbursing 51 providers for the ADS they provided to 1,280 consumers.

At the end of December 2012, ODA's Alzheimer's Respite Programs was reimbursing 31 providers for the ADS they provided to 560 consumers.

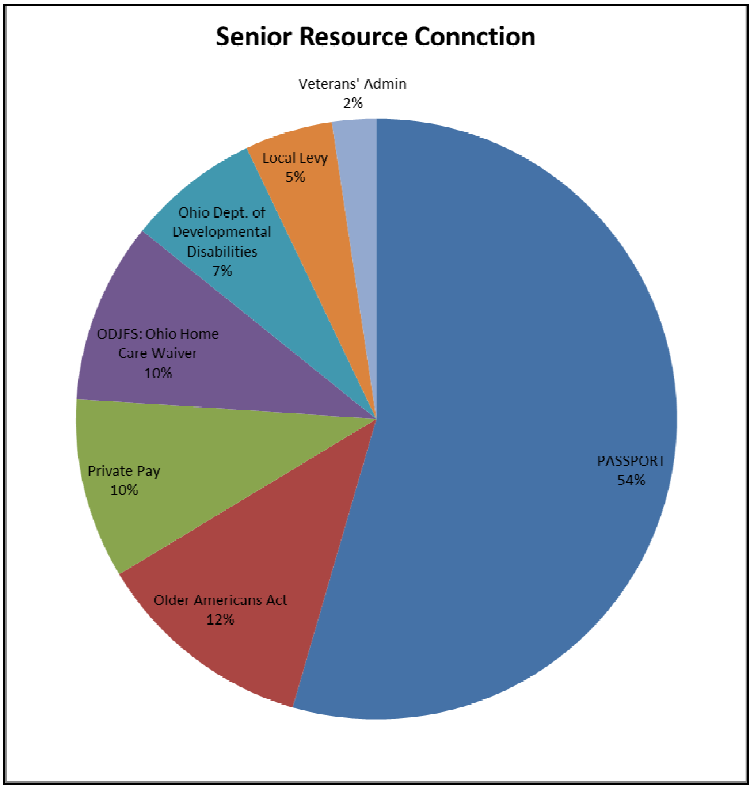
b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

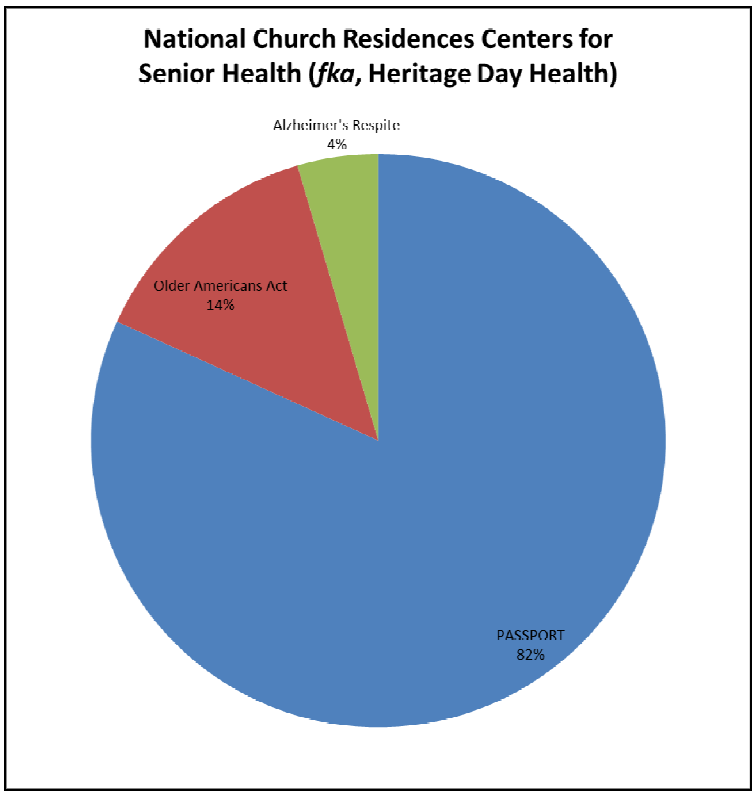
When a provider identified in #14a provides ADS to consumers who are enrolled in ODA administered programs, they must generally comply with both rules 173-3-06.1 and 173-39-02.1 of the Administrative Code. ODA will comment on the adverse impacts of these two rules together, but break down the impact (or lack thereof) by topic.

UNIFORM RULES

Many providers are reimbursed for the ADS they provide to consumers by many sources, including ODA-administered programs. Nationwide, 55% of ADS revenue comes from publicly-funded programs. Of those programs, the most common sources of public funding are Medicaid home and community-based waiver programs (*i.e.*, ODA's PASSPORT Program), the Veterans' Administration, and state and local funding.[2] In Ohio, it appears that majority of the funding comes from two ODA-administered programs that are each regulated by a separate rule. This highlights the value of making ODA's two ADS rules uniform.

The pie charts below illustrate how an individual provider's business is responsible for complying with the regulations of numerous programs.





ODA's initiative to make its rules uniform should simplify meeting the regulatory requirements by making ODA's 2 sets of requirements as identical as possible.

Additionally, certain elements of ODA's proposed uniform language would reduce providers' regulatory burden, including: (1) giving providers, regardless of the program, an exception from the responsibility to provide transportation if the consumer or caregiver arranges for personal transportation from a source other than the provider; and (2) only requiring providers to include *major* life events in a consumer's social profile instead of including their life events (in general), which applied literally, would be excessive; and (3) using the same language regarding employing physician assistants, clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to provide health assessments, activity plans, and plans of treatment. (See more on (3) below under "**PLANS OF TREATMENT**."

PLANS OF TREATMENT

Ordering plans of treatment includes ordering therapeutic diets, nursing services, nutrition consultations, physical therapy, or speech therapy. Although Chapter 4730 of the Revised Code would allow a physician assistant to do so, and Chapter 4723 of the Revised Code would allow clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to do so, the current rules only allow *physicians* to order plans of treatment.

Therefore, ODA is proposing to amend rules 173-3-06.1 and 173-39-02.1 of the Administrative Code to allow physician assistants, clinical nurse specialists, certified nurse practitioners, and certified nurse-midwives to order plans of treatment for consumers receiving ADS.

This proposed new language would not create an adverse impact for any ADS provider. On the contrary, if an ADS provider's business model involves employing, or contracting with, medical professionals to develop plans of treatment in house, the proposed new language would allow the provider to employ, or contract with, physician assistants, clinical nurse specialists, certified nurse practitioners, or certified nurse-midwives to instead of physicians. The Bureau of Labor Statistics reports that the average mean wages for Ohio-based physician assistants, nurse practitioners, and nurse midwives is 49%, 48%, and 47% (respectively) of the wages of Ohio-based physicians.[12]

If an ADS provider's business model does not involve employing, or contracting with, medical professionals to develop plans of treatment in house, the consumers attending the ADS center would need to see a medical professional to obtain a plan of treatment. Therefore, the proposed new language would not create, nor reduce, an adverse impact upon such an ADS

[12] Bureau of Labor Statistics. "Occupational Employment Statistics: Occupational Employment and Wages." © May, 2012. (BLS reported that, in May, 2012, Ohio physicians (29-1069) received an annual mean wage of $184,210 while Ohio physician assistants (29-1071) received an annual mean wage of $89,800, Ohio nurse practitioners (29-1171) received an annual mean wage of $87,990, and Ohio nurse midwives (29-1161) received an annual mean wage of $86,560.)

provider with this business model. However, for the physicians' offices that examine the consumers who attend such ADS centers, the proposed new language could lower the cost of doing business by allowing physician assistants in those offices to develop the plans of treatment.

ELECTRONIC RECORDS

ODA's proposed amendments to explicitly permit providers to retain records electronically instead of on paper should give providers confidence that they do not need to maintain more-costly paper records and are able to email information (instead of using a parcel service) to Area Agencies on Aging, PASSPORT Administrative Agencies, and ODA when AAAs, PAAs, or ODA is monitoring them.

ADEQUATE SQUARE FOOTAGE AND TOILETS

ODA's current 60ft^2 of space requirement is modest in light of the average square footage for ADS centers, which is 194ft^2 per consumer.[13]

Because the current rules already require 60ft^2 per consumer, every provider presently engaged in business serving consumers who are enrolled in ODA's programs has already agreed to the square-footage requirements and is already being monitored by AAAs, PAAs, and ODA for compliance with this requirement. Therefore, ODA estimates that there will be no new adverse impact associated by overstating the requirement by adding the words, "regardless of the funding source for an individual's adult day services." However, the proposed new overstated language should prevent any providers from believing that it is permissible to squeeze consumers into any center with less than 60ft^2 per consumer.

Likewise, because the current rules already require at least 1 working toilet for every 10 consumers, every provider presently engaged in business serving consumers who are enrolled in ODA's programs has already agreed to the toilet requirements and is already being monitored by AAAs, PAAs, and ODA for compliance with this requirement. Therefore, ODA estimates that there will be no new adverse impact associated by overstating the requirement by adding the words, "regardless of the funding source for an individual's adult day services." However, the proposed new overstated language should prevent any providers from believing that it is permissible to operate a center with an insufficient number of working toilets.

As previously stated, an adequate number of toilets is more critical for consumers who receive ADS than the general population because 45% of the consumers who receive ADS require assistance with toileting.[14] Providing assistance with toileting implies lengthier times on toilets, which implies a

[13] MetLife Mature Market Institute, The Ohio State University College of Social Work, National Adult Day Services Association. "The MetLife National Study of Adult Day Services." © October, 2010. *Pg.*, 12.

[14] MetLife Mature Market Institute, The Ohio State University College of Social Work, National Adult Day Services Association. "The MetLife National Study of Adult Day Services." © October, 2010. *Pg.*, 23.

reduced availability of any given toilet, which indicates the need for an adequate supply of working toilets.

ACTIVITIES DIRECTORS

After ODA's online public-comment period, ODA relinquished its previous proposal to adopt uniform requirements for activities directors.

NON-SUBSTANTIVE

ODA's proposals to non-substantively amend the rules should create no adverse impact to any provider.

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The best estimates for the cost of providing the services begin with the recently-reported actual costs that providers of the services have billed the PASSPORT Program. The cost of serving consumers who are enrolled in Older Americans Act Programs and Alzheimer's Respite Programs is expected to be similar for the same ADS.

In FY 2012, the average per-member per-month expense for ADS for consumers who are enrolled in the PASSPORT Program was $654.60. This represents money paid *to* the impacted business community to reimburse them for their expenses.

In the appendix to rule 5101:3-1-06.1 of the Administrative Code, the Dept. of Job and Family Services established a maximum-allowable rates for ADS for the PASSPORT Program, which are $41.16 per day of enhanced ADS (or $1,234.80 per month if enhanced ADS is provided 30 days per month) and $54.03 per day of intensive ADS (or $1620.90 per month if intensive ADS is provided 30 days per month). In the appendix to rule 5101:3-1-06.4 of the Administrative Code, the Dept. of Job and Family Services established the maximum-allowable rates for ADS for the Choices Program, which are identical to the rates for the PASSPORT Program.

Although budget proposals are not part of this rule project, it is helpful to note that, for FY 2014, *pg*., 11 of the LSC Red Book for the Department of Aging says that H.B.59 (130th G.A.) will increase the maximum-allowable rates for ADS for the PASSPORT and Choices Programs by 20% which would bring the rates to $49.47 per day of enhanced ADS and $64.94 per day for a day of intensive ADS. This implies that JFS will address this in rules 5101:3-1-06.1 and 5101:3-1-06.4 of the Administrative Code. It is also helpful to note that H.B.59 also proposes a $100,000 per year increase in Alzheimer's Respite Program funds.

For the Older Americans Act Programs and the Alzheimer's Respite Programs, providers enter into competitively-bid contracts with area agencies on aging. Therefore, in their bid, the provider establishes the rate of reimbursement for ADS.

Multiple items identified in #14b could reduce the proposed new rules' adverse impact. These items include: (1) unifying the rules' language, including the transportation exceptions; (2) allowing certain non-physician professionals to develop plans of treatment; and, (3) explicitly allowing electronic records.

Multiple items identified in #14b would have no effect on the proposed new rules' adverse impact because the proposed new language only clarifies the current regulations. These items include: (1) clarifying language on adequate square footage and toilets and (2) replacing "recreational therapy or a related degree" with a list of degrees, licenses, and certifications that are related to recreational therapy.

Only one of ODA's proposals that ODA had proposed during the time of ODA's online public-comment period could have created a new adverse impact. It would have been ODA's previous proposal to require providers to no longer hire new activities directors only on the basis of job experience. When ODA polled a selection of providers about eliminating 2 years of job experience as an a sole means for qualifying to become an activities director,[15] most providers indicated that they were unconcerned with the proposed new language—probably because they already employed activities directors who qualified for reasons other than solely job experience. However, two provider organizations claimed that the proposed new language could cause providers to replace current activities directors with new ones who have degrees, licenses, or certificates.

In response to the input of the two provider organizations, ODA had proposed an alternate strategy that would have minimized the adverse impact upon providers who serve consumers who are enrolled in ODA's programs with activities directors who only qualify for their jobs on the basis of job experience. ODA now proposes to (1) require activities directors to possess certain degrees, OT or PT licenses, or national certification without requiring any job experience outside of the training necessary to obtain those degrees, licenses, or certifications; but (2) grandfather in current activities directors who qualifies for their positions solely on the basis of 2 years of job experience if the provider hired the person into the activities-director position before July 1, 2013. The alternate strategy would have eliminated any

[15] As previously stated in #7, when ODA contacted the providers on March 19, 2013, ODA's initial proposal to eliminate qualifying for the position solely on the basis of job experience was to require a recreational therapy degree *and* job experience as a qualification for the activities-director position.

adverse impact upon providers who are retaining their current activities directors.

Therefore, under ODA's alternate strategy, a provider that serves consumers who are enrolled in ODA's programs would have only encountered a new adverse impact if, after the adoption of the proposed new rules, the provider would attempted to hire an applicant for the position of activities director, but only if the provider would have paid higher wages for the applicant who has a degree, license, or certificate than the provider would have paid a person who only qualified under the previous means to qualify based upon 2 years of job experience.

However, after ODA received multiple comments on the topic during its online public-comment period, ODA relinquished its previous proposal to adopt uniform requirements for activities directors.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

After ODA relinquished its previous proposal to adopt uniform requirements for activities directors, the proposed new rules no longer had language in that that would have created a new adverse impact upon providers.

Business Impact Analysis

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Sections 173.391 and 173.392 of the Revised Code, as well as rules 173-3-06.1 and 173-39-02.1 of the Administrative Code, do not prescribe alternate means for compliance depending on the size of the business. Additionally, almost all providers would be small businesses.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Section 119.14 of the Revised Code establishes the exemption from penalties for first-time paperwork violations. Disciplinary actions by ODA (or its designees) resulting from non-compliance that is not a pattern of non-compliance is subject to section 119.14 of the Revised Code.

18. What resources are available to assist small businesses with compliance of the regulation?

The staff at Area Agencies on Aging (AAAs), PASSPORT administrative agencies (PAAs), and ODA are available to help direct-care providers of any size with their questions about the statutes and rules. Providers may address their questions to the AAAs, PAAs, or ODA (including ODA's regulatory ombudsman).