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Comments on Draft Rule 173-39-02.16 of the Administrative Code
September 28, 2023

Thank you for the opportunity to provide comments on the Ohio Department of Aging's (ODA's) draft amendments to the waiver provider certification rule (OAC 173-39-02.16) for assisted living. The amendments are intended to support enhanced reimbursement for memory care in waiver settings, as prescribed by House Bill (HB) 33.

The Ohio Health Care Association (OHCA) represents 312 assisted living providers, many of which are certified for waiver services and many of which provide memory care. OHCA was a strong proponent of the provisions of HB 33 establishing memory care reimbursement under the waiver. On behalf of our members, we have a keen interest in assuring that the regulatory standards for memory care reimbursement do not place undue burdens or costs on providers that frustrate the legislative intent of expanding access to this hitherto-unavailable but much-needed service.

Currently, waiver consumers do not have access to memory care in assisted living because the cost of providing the service far outstrips the existing reimbursement. The legislature in HB 33 attempted to solve this problem by calling for enhanced waiver reimbursement for memory care. Unfortunately, the Department of Medicaid has not yet published the enhanced memory care rate. Nonetheless, we do not want to witness the benefit of the enhanced reimbursement being diluted by regulatory burdens that increase providers' costs and impede their ability to offer memory care to waiver consumers.

Turning to the specific provisions of the draft rule:

- Paragraph (B) of the draft rule reads, "ODA certifies each provider for either the basic assisted living service or memory care. If ODA certifies a provider to provide memory care, the provider may also directly provide, or arrange for, the basic service." We think making certification an either/or proposition is too limiting. Most assisted living communities that offer memory care do so within a designated unit, while the remainder of the community furnishes what ODA terms "basic assisted living service." While the draft rule allows a memory care-certified provider also to offer the basic service, we feel it would be more appropriate to certify these dual service providers for both basic assisted living and memory care. Those who provide only one or the other would receive a single certification.

  We recommend modifying the language to read, "ODA certifies each provider for the basic assisted living service or memory care or grants dual certification if the provider offers both services." The second sentence could be deleted.

- In paragraph (D)(2)(a), ODA proposed the following language: “The provider has a mission statement that includes how its memory care differs from its basic assisted living service.” From our conversation on September 13, we understand that the intent of this provision is to require a certified “dual” provider (as we suggest above) to clarify for consumers how their memory care service differs from their basic AL service. We believe this language is inappropriate for a mission statement and would create unnecessary administrative burdens for not-for-profit (and potentially some for-profit) providers who are required to obtain board approval and align their mission statement with the overarching mission of the organization, which often provides more than assisted living memory care services.

  We recommend deleting proposed paragraph (D)(2)(a) and moving the concept to a more appropriate location, the paragraph on disclosure of public information, (C)(2)(b), specifically subparagraph (ii). The revised language would require the provider to disclose: “(ii) Whether the provider is certified by ODA to provide memory care, and if so, how its memory care differs from its basic assisted living service.”

- Paragraph (D)(2)(b) as proposed would require a memory care community to provide or arrange for “at least three activities, as listed in rule 3701-16-11 of the Administrative Code, each day, with consideration given to each individual's preferences and needs.” The referenced licensure regulation does not give a list of activities but more a generic description - “varied activities of sufficient quantity so that residents' lives may be more meaningful, to stimulate physical and mental capabilities and to assist residents in attaining their optimal social, physical, and emotional well-being” - with a few examples added. The proposed wording should be clarified.

  Also, the second sentence of the paragraph, “The coordination of these activities is separate from the coordination in paragraph (A)(1)(b)(iv) of this rule," is confusing and appears to suggest that the required activities could not include community integration such as trips outside the facility. To the extent community integration activities are made available to memory care residents, they should count as activities offered.

  We recommend revising the paragraph to read, “The provider provides or arranges for at least three of the therapeutic, social, or recreational activities prescribed by rule 3701-16-11 of the Administrative Code, each day, with consideration given to each individual's preferences and needs.” The second sentence about community activities should be deleted.

- We have concerns about the language of paragraph (D)(2)(c) of the draft, which mandates that “the provider ensures safe access at any time to outdoor space for all individuals.” The specific portion that is troubling is “at any time.” There are a variety of factors, such as staffing constraints or inclement weather, that make outdoor access unsafe at certain times. We recommend deleting the words “at any time,” as the term “safe access” is sufficient to capture both concepts: that everyone should have access

the outdoors, but also that the access should be provided in a manner that keeps residents safe.

- In paragraph (D)(2)(e) of the draft, we strongly oppose the proposed requirement for an assisted living memory care provider to employ a medical director. The job duties described in paragraphs (D)(2)(e)(i)- (v), with the exception of (iii), do not describe traditional functions of a medical director, nor do they require a physician to conduct. Additionally, physicians are largely unavailable throughout the state and very costly to employ, with the average physician salary in Ohio around $208,000 a year. Assisted living facilities vary considerably in size and in resident characteristics, and smaller or social model providers would be unable to support this requirement, further limiting access to services.

  Assisted living communities typically employ resident care coordinators or memory care directors who are responsible for overseeing the memory care unit, including meeting periodically with staff to discuss population management, acting as a liaison between the attending physician and other health professionals, reviewing facility QAPI plans, and adhering to person-centered planning. We agree that an assisted living memory care provider should designate a professional to perform these functions. We disagree, however, that a physician needs to hold this position.

  We suggest changing the term "medical director" to "memory care director" in paragraph (D)(2)(e) and adding a definition to paragraph (A) as follows: "'Memory care director' means a person with experience and training in dementia care who carries out the functions outlined in section (D)(2)(e) of this rule."

  Furthermore, with regard to paragraph (D)(2)(e)(iii) about back-up for residents' attending physicians in the event of urgent needs, it is important to recognize that most assisted living residents, including those with dementia, see community physicians or nurse practitioners who often do not make rounds at the facility. The requirement should incorporate the back-up plans established by the community practices.

  We recommend that if the department wishes to retain this provision, a new (D)(2)(f) should be added to state, "The provider maintains documentation of the protocols established by residents' personal physicians or other practitioners for coverage if the personal practitioner is unavailable."

- Paragraph (D)(3)(b) of the draft rule requires that, "The provider has a sufficient number of RNs, or LPNs under the direction of an RN, on call available at all times for individuals receiving memory care." We agree with requiring sufficient nursing, but the words "on call available" are confusing. On call means not present at the facility, but can be called, while available suggests being present. We recommend revising the language to state, "The provider has a sufficient number of RNs, or LPNs under the direction of an RN, on-call or on-site at all times for individuals receiving memory care."

- We have strong concerns about paragraph (D)(3)(c) of the proposal, which prescribes a "one-size-fits-all" staffing ratio for memory care units and an additional requirement for multiple-floor memory care units or buildings. As written, the staffing requirements consider only staff members who perform personal care services. While we do not agree with these proposed requirements, it is immaterial because they exceed ODA's statutory authority to adopt as rules. The legislature specifically prescribed staffing requirements for waiver memory care in HB 33, section 333.240. ODA cannot discard the statutory provisions and substitute its own staffing requirements. The statute provides:

  > The memory care unit in which the resident resides has a direct care staff to resident ratio that is at least twenty per cent higher than other units in the residential care facility. If the memory care unit is an entire residential care facility, the facility in which the resident resides has a direct care staff to resident ratio that is at least twenty per cent higher than the average direct care staff to resident ratio of a representative sample of residential care facilities participating in the Medicaid-funded component of the assisted living program or parts of those facilities that are not memory care units.

  This statute does not require waiver memory care units to meet a one-size-fits-all staffing ratio, but gauges memory care staffing by comparison to the rest of the assisted living community. Only if the building is all memory care does the legislation authorize ODA to set a staffing ratio, and even then the legislature prescribed that the standard must be based on a representative sample of non-memory care waiver providers.

  ODA recently did a survey of assisted living communities, which would have been the perfect opportunity to determine the average staffing of non-memory care waiver providers, but among all the questions on the survey, ODA did not ask the one required by the statute. The survey only asked about staffing in memory care units, not parts of waiver communities that are not dedicated to memory care. As a result, Aging does not yet have the data the statute requires to support a baseline staffing ratio for the limited purpose of all-memory care waiver buildings.

  In addition, the draft rule's application of the staffing requirements to staff members who provide personal care is inconsistent with the statute, which uses the term "direct care staff" and defines that term as including "nurses, resident care assistants, activities personnel, and social services personnel who are employed by or contracted with a residential care facility." The term used in the rule is more restrictive than the statute because it excludes activities personnel and social services personnel, who typically do not provide personal care but are defined as direct care staff by statute.

  To comply with the statute, we recommend deleting paragraph (D)(3)(c) and replacing it with the following language:

(c) The memory care unit has a direct care staff to resident ratio that is at least twenty per cent higher than other units in the residential care facility. If the memory care unit is an entire residential care facility, the facility in which the resident resides has a direct care staff to resident ratio that is at least _____ during waking hours and ____ during non-waking hours.

The two blanks would be filled in before the rule is filed by a quick survey that asks non-memory care waiver providers two questions: their waking hours staffing ratio and their non-waking hours staffing ratio, then taking 120% of each ratio.

We also recommend adding the following new definition to paragraph (A) of the rule: "'Direct care staff' includes nurses, resident care assistants, activities personnel, and social services personnel who are employed by or contracted with a residential care facility."

- We appreciate and support the flexibility in training options afforded by paragraph (D)(4) of the draft rule. In other states where assisted living memory care providers have been required to utilize a specific training program, we have found that providers struggle to access these specific programs or find them inapposite to the needs of their community. Allowing flexibility for the provider to select training, so long as it covers the specified topics, will ensure wide access to meet the training standard and support better compliance.

- We are unable to comment on the sufficiency of the rates as they have not been published with this proposed rule.

We appreciate the opportunity to provide feedback. Questions regarding these comments can be directed to Erin Hart, OHCA Strategy Director, at ehart@ohca.org.