OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

H.B. 676*
135th General Assembly

Occupational Regulation Report

Click here for H.B. 676's Bill Analysis / Fiscal Note

Primary Sponsors: Reps. Baker and Abrams

Impacted Profession: Operators and staff of prescribed pediatric extended care centers

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LSC is required by law to issue a report for each introduced bill that substantially changes or enacts an occupational regulation. The report must: (1) explain the bill's regulatory framework in the context of Ohio's statutory policy of using the least restrictive regulation necessary to protect consumers, (2) compare the regulatory schemes governing the same occupation in other states, and (3) examine the bill's potential impact on employment, consumer choice, market competition, and cost to government.[1]

LEAST RESTRICTIVE REGULATION COMPARISON

Ohio's general regulatory policy

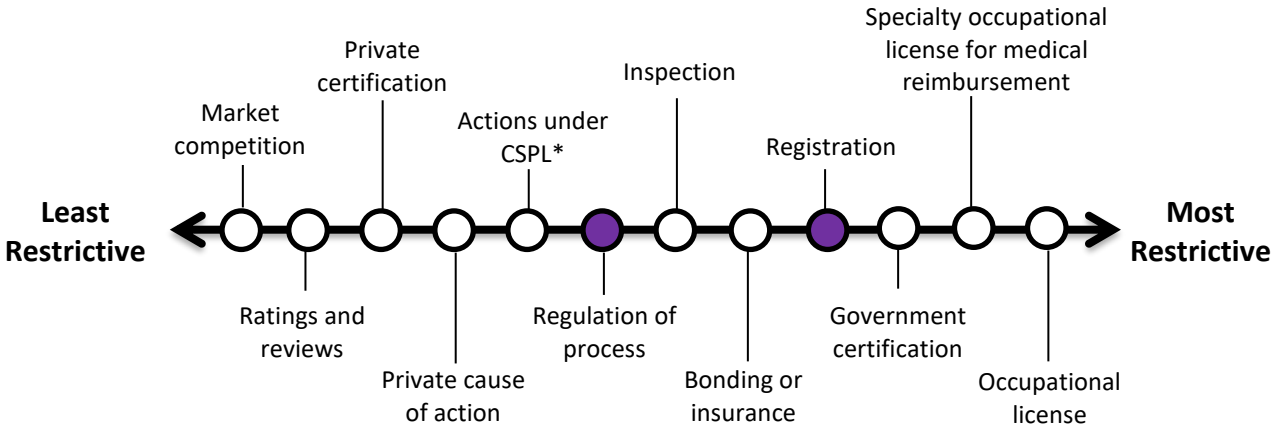
The general policy of the state is reliance on market competition and private remedies to protect the interests of consumers in commercial transactions involving the sale of goods or services. For circumstances in which the General Assembly determines that additional safeguards are necessary to protect consumers from "present, significant, and substantiated harms that threaten health, safety, or welfare," the state's expressed intent is to enact the "least restrictive regulation that will adequately protect consumers from such harms."[2]

The degree of "restrictiveness" of an occupational regulation is prescribed by statute. The following graphic identifies each type of occupational regulation expressly mentioned in the state's policy by least to most restrictive:

* This report addresses the "As Introduced" version of H.B. 676. It does not account for changes that may have been adopted after the bill's introduction.

[1] R.C. 103.26, not in the bill.

[2] R.C. 4798.01 and 4798.02, neither in the bill.



*CSPL – The Consumer Sales Practices Law

H.B. 676 establishes licensure requirements for operators of prescribed pediatric extended care (PPEC) centers and requires rulemaking to establish minimum qualifications for employment at the centers.[3]

The bill defines a PPEC center as a "facility other than a hospital, whether operated for profit or not, that provides and delivers, or allows for the provision of, services to medically dependent or technologically dependent children and their legal guardians."[4] PPEC centers may, for any part of the day, provide any of the following services, supports, and therapies:

- Medical, nursing, psychosocial, developmental education, social work, developmental, child life, psychological, and behavioral support services;
- Speech, occupation, and physical therapies;
- Services to meet the caregiver training needs of the child's legal guardian.[5]

Although it appears that this new license will generally function as a business license, the licensure requirements also apply to individuals. Please note that, under the state policy's definitions of licensure and registration, the license functions as a registration because it does not appear that personal qualifications are required to obtain it.[6]

Necessity of regulations

Representative Baker, one of the bill's primary joint sponsors, testified that the bill is necessary because PPEC programs offer daycare and early childhood education programs for children with complex medical needs. She explained that Ohio is facing a shortage of home health aides and services. Because of these shortages, children with complex medical needs essentially

[3] R.C. 3724.02 and 3724.05(A).

[4] R.C. 3724.01(F).

[5] R.C. 3724.06.

[6] R.C. 4798.01, not in the bill.

live in hospitals. Representative Baker also explained that for families who can find home health aides, children receive minimal socialization and inclusion in early childhood experiences, as they spend most of their time at home.

She also highlighted a study by a Southwest Ohio taskforce, which surveyed Child Care Resource and Referral Agencies representing all 88 counties regarding childcare access for children with complex medical conditions. She stated the study found that "89% reported 'poor access'" to childcare for children who require nursing staff services. She asserted that many families with children with complex medical needs find that communities do not have the resources for children to have a typical early childhood education experience, resulting in many of these families moving to Kentucky to receive a PPEC experience.

Representative Baker testified that many PPEC centers are designed for inclusivity. She explained that a portion of the children at the centers have complex medical needs, and the other portion are developing children. She said this fosters an inclusive learning environment where empathy and learning about children with different abilities can occur.

Representative Abrams, one of the bill's primary joint sponsors, testified that PPEC programs provide reliable and consistent early childhood education, which allows parents to remain in the workforce and reduce workplace absenteeism. She explained that PPEC centers provide a sense of comfort for families to know their children are receiving the treatment they need without needing to go to the hospital.[7]

Restrictiveness of regulations

Registration

As noted above, the PPEC center license established by the bill functions as a registration under the state policy.[8] The state's general policy specifies that a registration requirement is an appropriate means of protecting consumers against potential damages from transient service providers.[9] The bill's requirements, such as its eligibility criterion of holding a child care center license issued under continuing law, are likely to make PPEC centers more permanent and less transient. Thus, the bill's registration requirement appears to satisfy the state policy.

Eligibility criteria

The bill increases restrictiveness by requiring an individual seeking to operate a PPEC center to obtain a license from the Director of Health (although, in one sense, it decreases restrictiveness as these centers cannot currently be operated in Ohio). Under the bill, to be eligible for the license, an applicant must pay a $500 application fee (or $250 if the applicant already holds a PPEC center license) and must contract with or employ both of the following:

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[7] See Representative Baker and Representative Abrams's Sponsor Testimony (PDF), accessible on the General Assembly's website, legislature.ohio.gov, by searching for "HB 676" and looking under the "Committee Activity" tab.

[8] R.C. 4798.01, not in the bill.

[9] R.C. 4798.02(B)(4), not in the bill.

- A medical director who is a physician specializing in pediatric medicine and has at least three years of clinical experience in pediatric medicine;
- One or more nurse managers, with each being a registered nurse with clinical experience in pediatric nursing.

Additionally, the bill requires eligible applicants to hold a childcare center license issued under the continuing Child Day-care Law. The childcare center must be operated at the same address as the PPEC center.[10]

Renewal

A PPEC center license is valid for three years and can be renewed. For renewal, a PPEC center must pay a $500 fee, hold a valid childcare center license, and meet the requirements established in rules adopted by the Director of Health.[11]

Penalties

The bill increases restrictiveness by establishing penalties. An individual who operates a PPEC center without a license is subject to a fine between $500 and $10,000 for each offense.[12] The Department of Health may refuse to issue or renew, suspend, or revoke a license and may impose up to $500 in civil penalties for each violation of the bill and for each day a violation continues.[13]

In addition, the violator may be subject to discipline, including license suspension or revocation, for reasons that the Director must establish by rule.[14]

Regulation of process

The state's policy does not provide specific guidance as to when a regulation of process is the best means of protecting the health, safety, and welfare of consumers. However, the policy as a whole suggests that regulations of process are the most preferred method of regulation when market competition, ratings and reviews, private certifications, private causes of action, and actions under the state's Consumer Sales Practices Law do not provide sufficient protection.[15] Whether these mechanisms are a sufficient means of protecting consumers is a policy decision.

[10] R.C. 3724.03(B).

[11] R.C. 3724.04.

[12] R.C. 3724.99.

[13] R.C. 3724.09.

[14] R.C. 3724.05

[15] R.C. 4798.01, not in the bill.

PPEC centers

The bill increases restrictiveness by establishing process regulations for PPEC centers. Under the bill, a center must comply with all of the following requirements that must be established in rules adopted by the Director:

- Standards for providing and delivering services and for maintaining physical surroundings at the center;
- Minimum qualifications for employment and for specified training;
- Requirements for maintaining medical records that must be kept under the bill and other information.[16]

In addition, the center must maintain specified child-to-staff ratios involving registered nurses and licensed practical nurses.[17]

The center also must assist the Department of Health in any audits it conducts under the bill.[18]

Medical director

The bill increases restrictiveness by requiring a center's medical director to develop a child's treatment plan. The treatment plan must be made in consultation with the child's physician and parent or legal guardian and must outline therapeutic interventions and skilled nursing supervision. The bill requires the director to review each child's treatment plans and medical records at least once a month, updating the plan as necessary. The director must also be available either in person or electronically to consult with the center's staff.[19]

Nursing staff

The bill requires a nurse manager or nurse manager's designee to be present at the center during its hours of operation. The center's nurse manager must coordinate the implementation of a treatment plan. The treatment plan's interventions and skilled nursing must be administered by either a registered nurse employed by the center, or a licensed practical nurse employed by the center and under direct supervision of the registered nurse.[20]

Medical transportation services

The bill increases restrictiveness by establishing process regulations for PPEC center medical transportation services. Under the bill, they must comply with all of the following requirements that must be established by rule of the Director of Health:

[16] R.C. 3724.05 and 3724.07(C).

[17] R.C. 3724.07(A).

[18] R.C. 3724.05 and 3724.07(D).

[19] R.C. 3724.08.

[20] R.C. 3724.07(B) and 3724.08(B).

- Establish standards for providing medical transportation services to and from PPEC centers;
- Ensure nursing support is available when such services are provided;
- Prohibit a medical transportation services provider from providing services if the provider is related to the center's owner or operator by blood, marriage, or adoption.[21]

IMPACT STATEMENT

Opportunities for employment

By establishing licensure requirements for PPEC centers, the bill will create a new health care center type in Ohio and increase opportunities for employment for qualified physicians who work with and in PPEC centers as medical directors. The creation of the PPEC centers will also increase opportunities for employment for qualified nurse managers who work with and in PPEC centers.

Consumer choice and market competition

By creating a new center type to provide care to medically or technologically dependent children, the bill will increase care options for these children. This should increase consumer choice among these children and their parents or guardians, and create market competition among licensed PPEC centers.

Cost to government

For costs to government, please see the LSC fiscal note (PDF).

SUMMARY OF PROPOSED REGULATIONS

The bill requires the Director of Health to adopt rules in accordance with Ohio's Administrative Procedure Act that are related to the licensure and regulation of PPEC centers.[22] For a detailed summary of the bill's requirements regarding prescribed pediatric extended care centers, please see the LSC bill analysis (PDF).

COMPARISON TO OTHER STATES

Of the five surrounding states, Kentucky and Pennsylvania have prescribed pediatric extended care center licensure requirements. Both states' regulations appear to be registrations for purposes of Ohio's Occupational Regulations Law.

[21] R.C. 3724.05(A)(7).

[22] R.C. 3724.05.

Kentucky requires a certificate of need and a license to operate PPEC center.[23] A license is valid for one year and can be renewed. An initial license and renewal fee is $500.[24]

Pennsylvania requires a license to operate a pediatric extended care center. A license is valid for one year and can be renewed. An application and renewal fee are $500. An applicant is required to provide proof that a bond has been posted and proof of adequate liability insurance.[25]

INFORMATION FROM SPONSOR

Sponsors of bills involving occupational regulations are expressly permitted by law to provide LSC with information that may be relevant to this report.[26] The information below was submitted by Representative Cindy Abrams. It has been reformatted to fit the structure of the report but is otherwise reproduced in its entirety. Inclusion of sponsor-provided information in this section is not an endorsement or affirmation of accuracy by LSC.

October 2023

Child Care Access for Children and Youth with Special Health Care Needs in Ohio

Issue: Children and youth with special health care needs (CYSHCN) lack access to child care and early learning programs in Ohio due to their underlying medical conditions and the complexity of the daily care they require. The lack of child care access impedes parents' ability to participate in the workforce and financially support their families. In addition, inadequate availability of child care and home nursing resources for CYSHCN contributes to extended hospitalizations that are not medically necessary and extremely costly for Ohio Medicaid and private insurers.

Population at risk: Children with special health care needs (CYSHCN) are defined by the Maternal and Child Health Bureau as children and youth who "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health related services of a type or amount beyond that required by children generally" (McPherson, et al., 1998), have disproportionately high use of the health care system, and may experience disparate health outcomes (Brown et al, 2021, Simon et al, 2010). In the US, 19% of children have a special health care need, and recent data estimates 537,387 children in Ohio (20.95%) have special health care needs (Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health [NSCH] data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services).

A further subset of CYSHCN is children with medical complexity (CMC), defined as children who have multiple chronic conditions, severe functional limitations, may rely on the use of medical technology (i.e., feeding tube, tracheostomy tube), and have high health use (including home

[23] Ky. Rev. Stat. 216.885.

[24] 902 Ky. Admin. Regs. 20:008.

[25] 35 P.S. 449.66, 449.67, and 449.69.

[26] R.C. 103.26(D), not in the bill.

nursing, respite care, and palliative care (Cohen et al., 2011). It is estimated that CMC comprise <1% of all US children (Murphy et al., 2020) but the number of CMC in the US doubled in the past decade (Yu et al., 2022). Additionally, despite the low prevalence of CMC, their health care costs account for 86% of pediatric hospital charges and 30 % of pediatric health care costs for all US children (Murphy et al., 2020).

Lack of access: The lack of access to child care is a well-documented, universal crisis across Ohio but is particularly acute for children with medical needs. In March 2023, a southwest Ohio taskforce surveyed Child Care Resource and Referral Agencies (CCR&Rs) representing all 88 Ohio counties regarding child care access for CMC. Alarmingly, 89% of CCR&Rs reported "poor access" (two or less child care placement options per county) for CMC who require nursing services to attend child care.

The results of a 2023 survey of social workers from all six of Ohio's children's hospitals (Akron, Toledo, Columbus, Cleveland, Dayton, and Cincinnati) further highlighted the child care access concerns. Of the 20 social workers surveyed, all reported that CMC requiring special child care accommodations, such as nursing care for medication management (seizures, type 1 diabetes, etc.), nutrition or g-tube feeding, and respiratory equipment (ventilators, suction machines, supplemental oxygen) have either no access or poor access to child care in their service area.

Increased Family Burden and Reduced Employment: The high financial costs of caring for a child with a disability are further compounded when parents lack the child care they need to participate in the workforce. Caregivers of these children often report high financial and social burdens and experience increased psychosocial stressors, financial instability, and poverty when they must leave employment to care for their children at home (Thomson et al. 2016, Baddour et al. 2021). These families often deal with forgone family employment due to their child's health condition, and research shows that foregone family employment is higher for families of children with intellectual disabilities, children 0-5 years of age, families of Hispanic ethnicity, and children who need increased hours of care (Foster, et al., 2021).

A secondary analysis of the NSCH data from 2016-2019 showed that nearly 50% of caregivers of US children with significant disabilities and medical complexities experienced work disruptions due to the lack of child care (Yu et al., 2022). Without access to child care programs, Ohio's most vulnerable children are excluded from important early learning and social opportunities with their peers, and their caregivers are unable to participate in Ohio's workforce.

Cost to Ohio Taxpayers: In addition to the impacts of reduced workforce participation and lower payroll tax revenue, caregivers of CYSHCN and CMC who experience forgone family employment are more likely to utilize public benefit programs (Foster, et al., 2021). The National Survey of Children's Health (2016- 2019) showed that two-thirds of caregivers of CMC reported receiving some form of government assistance such as cash assistance (Yu et al., 2022).

The lack of access to community child care and home nursing also contributes to avoidable hospital stays. Recent data from Cincinnati Children's Hospital underscores the significant financial cost to Ohio Medicaid and private insurers when CMC experience extended inpatient stays beyond the date, they are medically ready to go home. Internal hospital reports show that in 2022, Cincinnati Children's medically complex patients experienced a combined total of 3,952

avoidable inpatient days due to the lack of access to home and community nursing services. These avoidable hospital stays cost Ohio Medicaid and other insurers an estimated $22.5 million for Cincinnati Children's patients alone in 2022.

Proposed Solution: Prescribed Pediatric Extended Care (PPEC) programs are nonresidential community-based Medicaid waiver programs that began in the mid-1990s to address the critical need for medical child care. Since then, many states have adopted similar programs, some under different names. These states include Delaware, Florida, Kentucky, California, Colorado, Louisiana, Maryland, Minnesota, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, and South Carolina. Virginia is currently in the process of creating a program.

As an example, Easterseals Redwood, a Cincinnati-based non-profit, has been providing quality PPEC services in Northern Kentucky for more than a decade. A licensed five-star child care center, they currently provide child care to more than 140 children, 63 of whom are children with medical complexity. Over many years, they have worked with the Kentucky Department for Medicaid Services and other providers to improve services and adjust regulations to advance service delivery. The agency is well-positioned to replicate its successful PPEC model in southwest Ohio and other parts of Ohio in the future.

What could a PPEC program in Ohio look like: Ohio is in an advantageous situation to utilize the experience of a respected PPEC provider and the learnings from other states that have established PPEC programs in the design and implementation of a program that works for Ohio's children, families, and taxpayers. The addition of PPEC services in Ohio would provide a critically necessary service that would complete the vision set forth in the Ohio Promise for Inclusive Child Care by extending child care access to Ohio's most vulnerable children with medical complexities. The following are suggested guidelines for the creation of a PPEC program in Ohio.

Eligibility: Most states use a broad definition in describing eligibility, as opposed to listing specific diagnoses. This is usually because many children served in these programs have rare diseases, or several medical conditions, which together create the need for PPEC care. Examples of common diagnoses can be included, but it is vital that admission is not limited to specific diagnoses. Physicians need the flexibility to admit for one diagnosis or a combination of factors, which require a higher level of skilled care. In Kentucky and Minnesota for example, the language includes but is not limited to cerebral palsy, oxygen dependence, tracheostomy, feeding disorders, gastrostomy, diabetes, catheterization, ostomies, cardiac disease or defect, spinal cord injury, respiratory disease or disorder, genetic disorders, or complications from prematurity.

Other eligibility criteria include:

- A referral to the program by a licensed physician is required.
    - The child must remain under the care of a physician during PPEC utilization.
- The child must be either medically or technologically dependent.
    - The child requires skilled nursing care (RN and LPN staffing)
- The child must be medically stable prior to beginning PPEC services.
    - Once enrolled, a child may become medically unstable. However, they retain the option to return to PPEC services within a reasonable amount of time upon returning to their baseline status (usually six months or less).

- Medical regulations take priority over child care regulations for children receiving PPEC services. To qualify as a licensed PPEC provider, the provider must meet the minimum standards for providing child care. Additional information regarding medical care ratios is stated below.
- Children up to their 26th birthday may be eligible to attend PPEC centers with a prescription from their physician.
- PPEC services are available to school-age children after school hours and during school breaks.
- In most states eligibility and funding are approved by state Medicaid and private insurers.
- Payments to providers occur through Medicaid or Managed Care Organizations (MCO).
- There must be an appeals process for families who are denied PPEC services. Strict time limits for Medicaid/MCO response are needed.
- Eligibility for PPEC services is based on medical need and not determined by parental or caregiver income.

Nursing Services: States have varying standard ratios of children to nurses. The below is proposed to ensure appropriate oversight and related experience.

- A medical director is required to oversee and be available to consult.
    - They do not need to be onsite, but available to provide consultation and monthly patient care reviews.
- A nurse manager / supervisor / director is required in all states.
    - 5 years of direct pediatric experience are required.
    - The nurse manager/supervisor/director must be a site-based 1.0 FTE.
- Staff to child ratios for PPEC children receiving medical care
    - 2 to 12 children | 2 RN's, 2 other staff/child care provider
    - 13 to 20 children | 2 RN's, 1 LPN's, 3 other Staff/child care provider
    - 21 to 30 children | 3 RN's, 2 LPN's, 4 other Staff/child care provider
    - 31 and over | Add 1 Nurse for every 8 children

Attendance / Program Design: PPEC programs typically offer medical child care up to 12 hours per day. PPEC programs collaborate in service provision with community therapists, behavioral specialists, early intervention and Head Start professionals, and local school district personnel.

PPEC programs are not delivered at home for important reasons including:

- Utilizing resources to serve children in a group setting, as opposed to individual services at home
- Encouraging parents to return to the workforce or further their education
- Integrating children with medical complexity with "typically developing" children and siblings. Easterseals Redwood believes the integrated and inclusive nature of its programs benefits all children and is one of the reasons their program is in high demand.
    - Medically fragile and typically developing children learn from each other.
    - Inclusive programs challenge stigmas around disabilities.

- Inclusion promotes healthy social emotional skills for children.
- Children increase confidence through friendships.

Licensing / Oversight: PPEC programs are medical programs and fall under the appropriate medical agencies. Child care regulations are secondary to medical regulations for children receiving PPEC services.

- Provider Agencies must have an internal compliance program for children's records (i.e., physician orders, updated medication lists, disclosure of medication errors, regular audits, etc.).
- Provider agencies participate in audits at least once annually for service delivery and billing.

Transportation: Transportation is often a barrier for families attempting to receive PPEC services, especially when children need specialized transportation due to their equipment or other needs. To maximize the effectiveness and utilization of the program, Easterseals Redwood recommends that:

- Transportation to and from PPEC centers is available for eligible patients who have a written prescription from their physician and the approval of the center's medical director.
- An RN must be in the vehicle.
- Costs for providing transportation and the nursing care required during the transport of eligible patients are reimbursed as an additionally prescribed service.

Provider Reimbursement Rates: Most states have one rate for all PPEC approved children. This following approach is recommended:

- Utilization of the hourly reimbursement rates for up to four hours
- Utilization of the daily reimbursement rates after four hours (12-hour maximum)
- Utilization of tiered levels of reimbursement is not recommended

This proposal is supported by:

Cincinnati Children's

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