If the governor finds that access to basic "Workforce Investment Act" services is not being provided in a local area, the governor may declare an emergency and, in consultation with the chief elected officials of the local area affected, arrange for provision of these services through an alternative entity during the time period in which resolution of the problem preventing service delivery in the local area is pending. An action taken by the governor pursuant to this section is not subject to appeal under this section.

Sec. 5101.244. If a county family services agency submits an expenditure report to the department of job and family services and the department subsequently determines that an allocation, advance, or reimbursement the department makes to the agency, or a cash draw the agency makes, for an expenditure exceeds the allowable amount for the expenditure, the department may adjust, offset, withhold, or reduce an allocation, cash draw, advance, reimbursement, or other financial assistance to the agency as necessary to recover the amount of the excess allocation, advance, reimbursement, or cash draw. The department is not required to make the adjustment, offset, withholding, or reduction in accordance with section 5101.24 of the Revised Code.

The director of job and family services may adopt rules under section 111.15 of the Revised Code as necessary to implement this section. The director shall adopt the rules as if they were internal management rules.

Sec. 5101.26. As used in this section and in sections 5101.27 to 5101.30 of the Revised Code:

(A) "County agency" means a county department of job and family services or a public children services agency.

(B) "Fugitive felon" means an individual who is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual is fleeing, for a crime or an attempt to commit a crime that is a felony under the laws of the place from which the individual is fleeing or, in the case of New Jersey, a high misdemeanor, regardless of whether the individual has departed from the individual's usual place of residence.

(C) "Information" means records as defined in section 149.011 of the Revised Code, any other documents in any format, and data derived from records and documents that are generated, acquired, or maintained by the department of job and family services, a county agency, or an entity performing duties on behalf of the department or a county agency.

(D) "Law enforcement agency" means the state highway patrol, an agency that employs peace officers as defined in section 109.71 of the Revised Code, the adult parole authority, a county department of probation,

a prosecuting attorney, the attorney general, similar agencies of other states, federal law enforcement agencies, and postal inspectors. "Law enforcement agency" includes the peace officers and other law enforcement officers employed by the agency.

(E) "Medical assistance provided under a public assistance program" means medical assistance provided under the programs established under sections 5101.49, 5101.50 to 5101.503, and 5101.51 to 5101.5110, ~~Chapters~~ Chapter 5111. ~~and 5115.~~, or any other provision of the Revised Code.

(F) "Public assistance" means financial assistance, medical assistance, or social services provided under a program administered by the department of job and family services or a county agency pursuant to Chapter 329., 5101., 5104., 5107., 5108., 5111., or 5115. of the Revised Code or an executive order issued under section 107.17 of the Revised Code.

(G) "Public assistance recipient" means an applicant for or recipient or former recipient of public assistance.

Sec. 5101.31. Any record, data, pricing information, or other information regarding a drug rebate agreement or a supplemental drug rebate agreement for the medicaid program established under Chapter 5111. of the Revised Code ~~or the disability medical assistance program established under section 5115.10 of the Revised Code~~ that the department of job and family services receives from a pharmaceutical manufacturer or creates pursuant to negotiation of the agreement is not a public record under section 149.43 of the Revised Code and shall be treated by the department as confidential information.

Sec. 5101.35. (A) As used in this section:

(1) "Agency" means the following entities that administer a family services program:

(a) The department of job and family services;

(b) A county department of job and family services;

(c) A public children services agency;

(d) A private or government entity administering, in whole or in part, a family services program for or on behalf of the department of job and family services or a county department of job and family services or public children services agency.

(2) "Appellant" means an applicant, participant, former participant, recipient, or former recipient of a family services program who is entitled by federal or state law to a hearing regarding a decision or order of the agency that administers the program.

(3) "Family services program" means assistance provided under a Title IV-A program as defined in section 5101.80 of the Revised Code or under

Chapter 5104., 5111., or 5115. or section 173.35, 5101.141, 5101.46, 5101.461, 5101.54, 5153.163, or 5153.165 of the Revised Code, other than assistance provided under section 5101.46 of the Revised Code by the department of mental health, the department of mental retardation and developmental disabilities, a board of alcohol, drug addiction, and mental health services, or a county board of mental retardation and developmental disabilities.

(B) Except as provided by ~~division~~divisions (G) and (H) of this section, an appellant who appeals under federal or state law a decision or order of an agency administering a family services program shall, at the appellant's request, be granted a state hearing by the department of job and family services. This state hearing shall be conducted in accordance with rules adopted under this section. The state hearing shall be tape-recorded, but neither the recording nor a transcript of the recording shall be part of the official record of the proceeding. A state hearing decision is binding upon the agency and department, unless it is reversed or modified on appeal to the director of job and family services or a court of common pleas.

(C) Except as provided by division (G) of this section, an appellant who disagrees with a state hearing decision may make an administrative appeal to the director of job and family services in accordance with rules adopted under this section. This administrative appeal does not require a hearing, but the director or the director's designee shall review the state hearing decision and previous administrative action and may affirm, modify, remand, or reverse the state hearing decision. Any person designated to make an administrative appeal decision on behalf of the director shall have been admitted to the practice of law in this state. An administrative appeal decision is the final decision of the department and is binding upon the department and agency, unless it is reversed or modified on appeal to the court of common pleas.

(D) An agency shall comply with a decision issued pursuant to division (B) or (C) of this section within the time limits established by rules adopted under this section. If a county department of job and family services or a public children services agency fails to comply within these time limits, the department may take action pursuant to section 5101.24 of the Revised Code. If another agency fails to comply within the time limits, the department may force compliance by withholding funds due the agency or imposing another sanction established by rules adopted under this section.

(E) An appellant who disagrees with an administrative appeal decision of the director of job and family services or the director's designee issued under division (C) of this section may appeal from the decision to the court

of common pleas pursuant to section 119.12 of the Revised Code. The appeal shall be governed by section 119.12 of the Revised Code except that:

(1) The person may appeal to the court of common pleas of the county in which the person resides, or to the court of common pleas of Franklin county if the person does not reside in this state.

(2) The person may apply to the court for designation as an indigent and, if the court grants this application, the appellant shall not be required to furnish the costs of the appeal.

(3) The appellant shall mail the notice of appeal to the department of job and family services and file notice of appeal with the court within thirty days after the department mails the administrative appeal decision to the appellant. For good cause shown, the court may extend the time for mailing and filing notice of appeal, but such time shall not exceed six months from the date the department mails the administrative appeal decision. Filing notice of appeal with the court shall be the only act necessary to vest jurisdiction in the court.

(4) The department shall be required to file a transcript of the testimony of the state hearing with the court only if the court orders the department to file the transcript. The court shall make such an order only if it finds that the department and the appellant are unable to stipulate to the facts of the case and that the transcript is essential to a determination of the appeal. The department shall file the transcript not later than thirty days after the day such an order is issued.

(F) The department of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section, including rules governing the following:

(1) State hearings under division (B) of this section. The rules shall include provisions regarding notice of eligibility termination and the opportunity of an appellant appealing a decision or order of a county department of job and family services to request a county conference with the county department before the state hearing is held.

(2) Administrative appeals under division (C) of this section;

(3) Time limits for complying with a decision issued under division (B) or (C) of this section;

(4) Sanctions that may be applied against an agency under division (D) of this section.

(G) The department of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code establishing an appeals process for an appellant who appeals a decision or order regarding a Title IV-A program identified under division (A)~~(3)~~(4)(c) ~~or~~, (d), (e), or (f) of

section 5101.80 of the Revised Code that is different from the appeals process established by this section. The different appeals process may include having a state agency that administers the Title IV-A program pursuant to an interagency agreement entered into under section 5101.801 of the Revised Code administer the appeals process.

(H) If an appellant receiving medicaid through a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code is appealing a denial of medicaid services based on lack of medical necessity or other clinical issues regarding coverage by the health insuring corporation, the person hearing the appeal may order an independent medical review if that person determines that a review is necessary. The review shall be performed by a health care professional with appropriate clinical expertise in treating the recipient's condition or disease. The department shall pay the costs associated with the review.

A review ordered under this division shall be part of the record of the hearing and shall be given appropriate evidentiary consideration by the person hearing the appeal.

(I) The requirements of Chapter 119. of the Revised Code apply to a state hearing or administrative appeal under this section only to the extent, if any, specifically provided by rules adopted under this section.

Sec. 5101.36. Any application for public assistance gives a right of subrogation to the department of job and family services for any workers' compensation benefits payable to a person who is subject to a support order, as defined in section 3119.01 of the Revised Code, on behalf of the applicant, to the extent of any public assistance payments made on the applicant's behalf. If the director of job and family services, in consultation with a child support enforcement agency and the administrator of the bureau of workers' compensation, determines that a person responsible for support payments to a recipient of public assistance is receiving workers' compensation, the director shall notify the administrator of the amount of the benefit to be paid to the department of job and family services.

For purposes of this section, "public assistance" means medical assistance provided through the medical assistance program established under section 5111.01 of the Revised Code; Ohio works first provided under Chapter 5107. of the Revised Code; prevention, retention, and contingency benefits and services provided under Chapter 5108. of the Revised Code; disability financial assistance provided under Chapter 5115. of the Revised Code; or disability medical assistance provided under former Chapter 5115. of the Revised Code.

Sec. 5101.46. (A) As used in this section:

(1) "Title XX" means Title XX of the "Social Security Act," 88 Stat. 2337 (1974), 42 U.S.C.A. 1397, as amended.

(2) "Respective local agency" means, with respect to the department of job and family services, a county department of job and family services; with respect to the department of mental health, a board of alcohol, drug addiction, and mental health services; and with respect to the department of mental retardation and developmental disabilities, a county board of mental retardation and developmental disabilities.

(3) "Federal poverty guidelines" means the poverty guidelines as revised annually by the United States department of health and human services in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C.A. 9902, as amended, for a family size equal to the size of the family of the person whose income is being determined.

(B) The departments of job and family services, mental health, and mental retardation and developmental disabilities, with their respective local agencies, shall administer the provision of social services funded through grants made under Title XX. The social services furnished with Title XX funds shall be directed at the following goals:

(1) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

(2) Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

(3) Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;

(4) Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care;

(5) Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

(C)(1) All federal funds received under Title XX shall be appropriated as follows:

(a) Seventy-two and one-half per cent to the department of job and family services;

(b) Twelve and ninety-three one-hundreths per cent to the department of mental health;

(c) Fourteen and fifty-seven one-hundreths per cent to the department of mental retardation and developmental disabilities.

(2) Each state department shall, subject to the approval of the controlling board, develop formulas for the distribution of their Title XX appropriations to their respective local agencies. The formulas shall take into account the total population of the area that is served by the agency, the percentage of the population in the area that falls below the federal poverty guidelines, and the agency's history of and ability to utilize Title XX funds.

(3) Each of the state departments shall expend no more than three per cent of its Title XX appropriation for state administrative costs. Each of the department's respective local agencies shall expend no more than fourteen per cent of its Title XX appropriation for local administrative costs.

(4) The department of job and family services shall expend no more than two per cent of its Title XX appropriation for the training of the following:

(a) Employees of county departments of job and family services;

(b) Providers of services under contract with the state departments' respective local agencies;

(c) Employees of a public children services agency directly engaged in providing Title XX services.

(D) The department of job and family services shall prepare a biennial comprehensive Title XX social services plan on the intended use of Title XX funds. The department shall develop a method for obtaining public comment during the development of the plan and following its completion.

For each state fiscal year, the department of job and family services shall prepare a report on the actual use of Title XX funds. The department shall make the annual report available for public inspection.

The departments of mental health and mental retardation and developmental disabilities shall prepare and submit to the department of job and family services the portions of each biennial plan and annual report that apply to services for mental health and mental retardation and developmental disabilities. Each respective local agency of the three state departments shall submit information as necessary for the preparation of biennial plans and annual reports.

(E) Each county department shall adopt a county profile for the administration and provision of Title XX social services in the county. In developing its county profile, the county department shall take into consideration the comments and recommendations received from the public by the county family services planning committee pursuant to section 329.06 of the Revised Code. As part of its preparation of the county profile, the county department may prepare a local needs report analyzing the need for Title XX social services.

The county department shall submit the county profile to the board of county commissioners for its review. Once the county profile has been approved by the board, the county department shall file a copy of the county profile with the department of job and family services. The department shall approve the county profile if the department determines the profile provides for the Title XX social services to meet the goals specified in division (B) of this section.

(F) ~~Not less often than every two years, the departments of job and family services, mental health, and mental retardation and developmental disabilities each shall commission an entity independent of itself to conduct an audit of its Title XX expenditures in accordance with generally accepted auditing principles. Within thirty days following the completion of its audit, each department shall submit a copy of the audit to the general assembly and to the United States secretary of health and human services.~~

~~(G)~~ Any of the three state departments and their respective local agencies may require that an entity under contract to provide social services with Title XX funds submit to an audit on the basis of alleged misuse or improper accounting of funds. ~~The~~ If an audit is required, the social services provider shall reimburse the state department or local agency for the cost it incurred in conducting the audit or having the audit conducted.

If an audit demonstrates that a social services provider is responsible for one or more adverse findings, the provider shall reimburse the appropriate state department or its respective local agency the amount of the adverse findings. The amount shall not be reimbursed with Title XX funds received under this section. The three state departments and their respective local agencies may terminate or refuse to enter into a Title XX contract with a ~~provider of~~ social services provider if there are adverse findings in an audit that are the responsibility of the provider. ~~The amount of any adverse findings shall not be reimbursed with Title XX funds. The cost of conducting an audit shall be reimbursed under a subsequent or amended Title XX contract with the provider.~~

~~(H) If federal funds received by the department of job and family services for use under Chapters 5107. and 5108. of the Revised Code are transferred by the controlling board for use in providing social services under this section, the distribution and use of the funds are not subject to the provisions of division (C) of this section. The department may do one or both of the following with the funds:~~

~~(1) Distribute the funds to the county departments of job and family services;~~

~~(2) Use the funds for services that benefit individuals eligible for~~

~~services consistent with the principles of Title IV-A of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.~~

~~(I) Except for the authority to adopt rules under division (J) of this section as necessary to carry out this division, this section does not apply to any distribution by the department of job and family services of funds for reimbursement of allowable Title XX expenditures when the funds for the reimbursement are received from a federal funding source other than Title XX.~~

~~(J)~~(G) The department of job and family services may adopt rules ~~necessary~~ to implement and carry out the purposes of this section. Rules ~~adopted under this division shall be adopted in accordance with Chapter 119. of the Revised Code, unless they are internal management rules governing fiscal and administrative matters. Internal~~ governing financial and operational matters of the department or matters between the department and county departments of job and family services shall be adopted as internal management rules ~~may be adopted~~ in accordance with section 111.15 of the Revised Code. Rules governing eligibility for services, program participation, and other matters pertaining to applicants and participants shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5101.461. (A) As used in this section:

(1) "Title IV-A" means Title IV-A of the "Social Security Act," 110 Stat. 2113 (1996), 42 U.S.C. 601, as amended.

(2) "Title XX" has the same meaning as in section 5101.46 of the Revised Code.

(B) To the extent authorized by federal law, the department of job and family services may use funds received through the Title IV-A temporary assistance for needy families block grant for purposes of providing Title XX social services. The amount used under this section shall not exceed the maximum amount permitted by federal law. The funds and provision of Title XX social services with the funds are not subject to section 5101.46 of the Revised Code.

(C) The department and any county department of job and family services may require an entity under contract to provide Title XX social services with funds used under this section to submit to an audit on the basis of alleged misuse or improper accounting of funds. If an audit is required, the social services provider shall reimburse the state department or county department for the cost it incurred in conducting the audit or having the audit conducted.

If an audit demonstrates that a social services provider is responsible for

one or more adverse findings, the provider shall reimburse the state department or county department the amount of the adverse findings. The amount shall not be reimbursed with funds received under this section. The state department and county departments may terminate or refuse to enter into a contract with a social services provider to provide services with funds available pursuant to this section if there are adverse findings in an audit that are the responsibility of the provider.

(D) The state department of job and family services may adopt rules to implement and carry out the purposes of this section. Rules governing financial and operational matters of the department or matters between the department and county departments of job and family services shall be adopted as internal management rules in accordance with section 111.15 of the Revised Code. Rules governing eligibility for services, program participation, and other matters pertaining to applicants and participants shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5101.47. (A) ~~The~~ Except as provided in division (B) of this section, the director of job and family services may accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for one or more of the following:

(1) The medicaid program established by Chapter 5111. of the Revised Code;

(2) The children's health insurance program parts I and II provided for under sections 5101.50 and 5101.51 of the Revised Code;

(3) Publicly funded child care provided under Chapter 5104. of the Revised Code;

(4) The food stamp program administered by the department of job and family services pursuant to section 5101.54 of the Revised Code;

(5) Other programs the director determines are supportive of children, adults, or families ~~with at least one employed member~~;

(6) Other programs regarding which the director determines administrative cost savings and efficiency may be achieved through the department accepting applications, determining eligibility, redetermining eligibility, or performing related administrative activities.

(B) If federal law requires a face-to-face interview to complete an eligibility determination for a program specified in or pursuant to division (A) of this section, the face-to-face interview shall not be conducted by the department of job and family services.

(C) Subject to division (B) of this section, if the director elects to accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for a program specified in or pursuant to

division (A) of this section, both of the following apply:

(1) An individual seeking services under the program may apply for the program to the director or to the entity that state law governing the program authorizes to accept applications for the program.

(2) The director is subject to federal statutes and regulations and state ~~law~~ statutes and rules that require, permit, or prohibit an action regarding accepting applications, determining or redetermining eligibility, and performing related administrative activities for the program.

~~(C)~~(D) The director may adopt rules as necessary to implement this section.

Sec. 5101.80. (A) As used in this section and in section 5101.801 of the Revised Code:

(1) "County family services agency" has the same meaning as in section 307.981 of the Revised Code.

(2) "State agency" has the same meaning as in section 9.82 of the Revised Code.

(3) "Title IV-A administrative agency" means both of the following:

(a) A county family services agency or state agency administering a Title IV-A program under the supervision of the department of job and family services;

(b) A government agency or private, not-for-profit entity administering a project funded in whole or in part with funds provided under the Title IV-A demonstration program created under section 5101.803 of the Revised Code.

(4) "Title IV-A program" means all of the following that are funded in part with funds provided under the temporary assistance for needy families block grant established by Title IV-A of the "Social Security Act," 110 Stat. 2113 (1996), 42 U.S.C. 601, as amended:

(a) The Ohio works first program established under Chapter 5107. of the Revised Code;

(b) The prevention, retention, and contingency program established under Chapter 5108. of the Revised Code;

(c) A program established by the general assembly or an executive order issued by the governor that is administered or supervised by the department of job and family services pursuant to section 5101.801 of the Revised Code;

(d) The kinship permanency incentive program created under section 5101.802 of the Revised Code;

(e) The Title IV-A demonstration program created under section 5101.803 of the Revised Code;

(f) A component of a Title IV-A program identified under divisions (A)~~(3)~~(4)(a) to ~~(e)~~(e) of this section that the Title IV-A state plan prepared under division (C)(1) of this section identifies as a component.

(B) The department of job and family services shall act as the single state agency to administer and supervise the administration of Title IV-A programs. The Title IV-A state plan and amendments to the plan prepared under division (C) of this section are binding on ~~county family services agencies and state agencies that administer a~~ Title IV-A ~~program~~ administrative agencies. No ~~county family services agency or state agency administering a~~ Title IV-A ~~program~~ administrative agency may establish, by rule or otherwise, a policy governing ~~the~~ a Title IV-A program that is inconsistent with a Title IV-A program policy established, in rule or otherwise, by the director of job and family services.

(C) The department of job and family services shall do all of the following:

(1) Prepare and submit to the United States secretary of health and human services a Title IV-A state plan for Title IV-A programs;

(2) Prepare and submit to the United States secretary of health and human services amendments to the Title IV-A state plan that the department determines necessary, including amendments necessary to implement Title IV-A programs identified in ~~division~~ divisions (A)~~(3)~~(4)(c) ~~and (d)~~ to (f) of this section;

(3) Prescribe forms for applications, certificates, reports, records, and accounts of ~~county family services agencies and state agencies administering a~~ Title IV-A ~~program~~ administrative agencies, and other matters related to Title IV-A programs;

(4) Make such reports, in such form and containing such information as the department may find necessary to assure the correctness and verification of such reports, regarding Title IV-A programs;

(5) Require reports and information from each ~~county family services agency and state agency administering a~~ Title IV-A ~~program~~ administrative agency as may be necessary or advisable regarding ~~the~~ a Title IV-A program;

(6) Afford a fair hearing in accordance with section 5101.35 of the Revised Code to any applicant for, or participant or former participant of, a Title IV-A program aggrieved by a decision regarding the program;

(7) Administer and expend, pursuant to Chapters 5104., 5107., and 5108. of the Revised Code and ~~section~~ sections 5101.801, 5101.802, and 5101.803 of the Revised Code, any sums appropriated by the general assembly for the purpose of those chapters and ~~section~~ sections and all sums

paid to the state by the secretary of the treasury of the United States as authorized by Title IV-A of the "Social Security Act," 110 Stat. 2113 (1996), 42 U.S.C. 601, as amended;

(8) Conduct investigations and audits as are necessary regarding Title IV-A programs;

(9) Enter into reciprocal agreements with other states relative to the provision of Ohio works first and prevention, retention, and contingency to residents and nonresidents;

(10) Contract with a private entity to conduct an independent on-going evaluation of the Ohio works first program and the prevention, retention, and contingency program. The contract must require the private entity to do all of the following:

(a) Examine issues of process, practice, impact, and outcomes;

(b) Study former participants of Ohio works first who have not participated in Ohio works first for at least one year to determine whether they are employed, the type of employment in which they are engaged, the amount of compensation they are receiving, whether their employer provides health insurance, whether and how often they have received benefits or services under the prevention, retention, and contingency program, and whether they are successfully self sufficient;

(c) Provide the department with reports at times the department specifies.

(11) Not later than January 1, 2001, and the first day of each January and July thereafter, prepare a report containing information on the following:

(a) Individuals exhausting the time limits for participation in Ohio works first set forth in section 5107.18 of the Revised Code.

(b) Individuals who have been exempted from the time limits set forth in section 5107.18 of the Revised Code and the reasons for the exemption.

~~(12) Not later than January 1, 2001, and on a quarterly basis thereafter until December 1, 2003, prepare, to the extent the necessary data is available to the department, a report based on information determined under section 5107.80 of the Revised Code that states how many former Ohio works first participants entered the workforce during the most recent previous quarter for which the information is known and includes information regarding the earnings of those former participants. The report shall include a county-by-county breakdown and shall not contain the names or social security numbers of former participants.~~

~~(13) To the extent authorized by section 5101.801 of the Revised Code, enter into interagency agreements with state agencies for the administration~~

~~of Title IV-A programs identified under division (A)(3)(c) and (d) of this section.~~

(D) The department shall provide copies of the reports it receives under division (C)(10) of this section and prepares under ~~divisions~~ division (C)(11) ~~and (12)~~ of this section to the governor, the president and minority leader of the senate, and the speaker and minority leader of the house of representatives. The department shall provide copies of the reports to any private or government entity on request.

(E) An authorized representative of the department or a county family services agency or state agency administering a Title IV-A program shall have access to all records and information bearing thereon for the purposes of investigations conducted pursuant to this section. An authorized representative of a government entity or private, not-for-profit entity administering a project funded in whole or in part with funds provided under the Title IV-A demonstration program shall have access to all records and information bearing on the project for the purpose of investigations conducted pursuant to this section.

Sec. 5101.801. (A) Except as otherwise provided by the law enacted by the general assembly or executive order issued by the governor establishing the Title IV-A program, a Title IV-A program identified under division (A)~~(3)~~(4)(c) ~~or,~~ (d), (e), or (f) of section 5101.80 of the Revised Code shall provide benefits and services that are not "assistance" as defined in 45 C.F.R. 260.31(a) and are benefits and services that 45 C.F.R. 260.31(b) excludes from the definition of assistance.

(B)(1) Except as otherwise provided by the law enacted by the general assembly or executive order issued by the governor establishing the Title IV-A program, the department of job and family services shall do either of the following regarding a Title IV-A program identified under division (A)~~(3)~~(4)(c) ~~or,~~ (d), (e), or (f) of section 5101.80 of the Revised Code:

~~(1)~~(a) Administer the program or supervise a county family services agency's administration of the program;

~~(2)~~(b) Enter into an interagency agreement with a state agency for the state agency to administer the program under the department's supervision.

(2) The department may enter into an agreement with a government entity and, to the extent permitted by federal law, a private, not-for-profit entity for the entity to receive funding for a project under the Title IV-A demonstration program.

(C) ~~If the department administers or supervises the administration of a Title IV-A program identified under division (A)(3)(c) or (d) of section 5101.80 of the Revised Code pursuant to division (B)(1) of this section, the~~

The department may adopt rules governing ~~the program~~ Title IV-A programs identified under divisions (A)(4)(c), (d), (e), and (f) of section 5101.80 of the Revised Code. Rules governing financial and operational matters of the department or between the department and ~~the~~ county family services ~~agency~~ agencies shall be adopted as internal management rules adopted in accordance with section 111.15 of the Revised Code. All other rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(D) If the department enters into an ~~interagency~~ agreement regarding a Title IV-A program identified under division (A)~~(3)~~(4)(c) ~~or (d)~~, (e), or (f) of section 5101.80 of the Revised Code pursuant to division (B)(1)(b) or (2) of this section, the agreement shall include at least all of the following:

(1) A requirement that the state agency or entity comply with the requirements for the program or project, including all of the following requirements established by federal statutes and regulations, state statutes and rules, the United States office of management and budget, and the Title IV-A state plan prepared under section 5101.80 of the Revised Code:

(a) Eligibility;

(b) Reports;

(c) Benefits and services;

(d) Use of funds;

(e) Appeals for applicants for, and recipients and former recipients of, the benefits and services;

(f) Audits.

(2) A complete description of all of the following:

(a) The benefits and services that the program or project is to provide;

(b) The methods of program or project administration;

(c) The appeals process under section 5101.35 of the Revised Code for applicants for, and recipients and former recipients of, the ~~program's~~ program or project's benefits and services;

(d) Other ~~program and administrative~~ requirements that the department requires be included.

(3) Procedures for the department to approve a policy, established by rule or otherwise, that the state agency or entity establishes for the program or project before the policy is established;

(4) Provisions regarding how the department is to reimburse the state agency or entity for allowable expenditures under the program or project that the department approves, including all of the following:

(a) Limitations on administrative costs;

(b) The department, at its discretion, ~~withholding~~ doing either of the following:

(i) Withholding no more than five per cent of the funds that the department would otherwise provide to the state agency or entity for the program or ~~charging~~ project;

(ii) Charging the state agency or entity for the costs to the department of performing, or contracting for the performance of, audits and other administrative functions associated with the program or project.

(5) If the state agency or entity arranges by contract, grant, or other agreement for another entity to perform a function the state agency or entity would otherwise perform regarding the program or project, the state ~~agency's~~ agency or entity's responsibilities for both of the following:

(a) Ensuring that the other entity complies with the ~~interagency~~ agreement between the state agency or entity and department and federal statutes and regulations and state statutes and rules governing the use of funds for the program or project;

(b) Auditing the other entity in accordance with requirements established by the United States office of management and budget.

(6) The state ~~agency's~~ agency or entity's responsibilities regarding the prompt payment, including any interest assessed, of any adverse audit finding, final disallowance of federal funds, or other sanction or penalty imposed by the federal government, auditor of state, department, a court, or other entity regarding funds for the program or project;

(7) Provisions for the department to terminate the ~~interagency~~ agreement or withhold reimbursement from the state agency or entity if either of the following occur:

(a) The federal government disapproves the program or project or reduces federal funds for the program or project;

(b) The state agency or entity fails to comply with the terms of the ~~interagency~~ agreement.

(8) Provisions for both of the following:

(a) The department and state agency or entity determining the performance outcomes expected for the program or project;

(b) An evaluation of the program or project to determine its success in achieving the performance outcomes determined under division (D)(8)(a) of this section.

(E) To the extent consistent with the law enacted by the general assembly or executive order issued by the governor establishing the Title IV-A program and subject to the approval of the director of budget and management, the director of job and family services may terminate a Title IV-A program identified under division (A)~~(3)~~(4)(c) ~~or,~~ (d), (e), or (f) of section 5101.80 of the Revised Code or reduce funding for the program if

the director of job and family services determines that federal or state funds are insufficient to fund the program. If the director of budget and management approves the termination or reduction in funding for such a program, the director of job and family services shall issue instructions for the termination or funding reduction. If a ~~county family services agency or state~~ Title IV-A administrative agency is administering the program, the ~~county family services agency or state~~ agency is bound by the termination or funding reduction and shall comply with the director's instructions.

(F) The director of job and family services may adopt internal management rules in accordance with section 111.15 of the Revised Code as necessary to implement this section. The rules are binding on each ~~county family services agency and state agency administering, pursuant to this section, a~~ Title IV-A ~~program identified in division (A)(3)(c) or (d) of section 5101.80 of the Revised Code~~ administrative agency.

Sec. 5101.802. (A) As used in this section:

(1) "Custodian," "guardian," and "minor child" have the same meanings as in section 5107.02 of the Revised Code.

(2) "Federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code.

(3) "Kinship caregiver" has the same meaning as in section 5101.85 of the Revised Code.

(B) Subject to division (E) of section 5101.801 of the Revised Code, there is hereby created the kinship permanency incentive program to promote permanency for a minor child in the legal and physical custody of a kinship caregiver. The program shall provide an initial one-time incentive payment to the kinship caregiver to defray the costs of initial placement of the minor child in the kinship caregiver's home. The program may provide additional permanency incentive payments for the minor child at six month intervals for a total period not to exceed thirty-six months.

(C) A kinship caregiver may participate in the program if all of the following requirements are met:

(1) The kinship caregiver applies to a public children services agency in accordance with the application process established in rules authorized by division (E) of this section;

(2) The minor child the kinship caregiver is caring for is a child with special needs as that term is defined in rules adopted under section 5153.163 of the Revised Code;

(3) A juvenile court has adjudicated the minor child to be an abused, neglected, dependent, or unruly child and determined that it is in the child's best interest to be in the legal custody of the kinship caregiver or the probate

court has determined that it is in the child's best interest to be in the guadianship of the kinship caregiver;

(4) The kinship caregiver is either the minor child's custodian or guardian;

(5) The minor child resides with the kinship caregiver pursuant to a placement approval process established in rules authorized by division (E) of this section;

(6) The gross income of the kinship caregiver's family, including the minor child, does not exceed two hundred per cent of the federal poverty guidelines.

(D) Public children services agencies shall make initial and ongoing eligibility determinations for the kinship permanency incentive program in accordance with rules authorized by division (E) of this section. The director of job and family services shall supervise public children services agencies' duties under this section.

(E) The director of job and family services shall adopt rules under division (C) of section 5101.801 of the Revised Code as necessary to implement the kinship permanency incentive program. The rules shall establish all of the following:

(1) The application process for the program;

(2) The placement approval process through which a minor child is placed with a kinship caregiver for the kinship caregiver to be eligible for the program;

(3) The initial and ongoing eligibility determination process for the program;

(4) The amount of the incentive payments provided under the program;

(5) The method by which the incentive payments are provided to a kinship caregiver;

(6) Anything else the director considers necessary to implement the program.

(F) The director shall begin implementation of the kinship permanency incentive program no later than January 1, 2006.

Sec. 5101.803. (A) Subject to division (E) of section 5101.801 of the Revised Code, there is hereby created the Title IV-A demonstration program to provide funding for innovative and promising prevention and intervention projects that meet one or more of the four purposes of the temporary assistance for needy families block grant as specified in 42 U.S.C. 601 and are for individuals with specific and multiple barriers to achieving or maintaining self-sufficiency and personal responsibility. The department of job and family services may provide funding for such projects to

government entities and, to the extent permitted by federal law, private, not-for-profit entities with which the department enters into agreements under division (B)(2) of section 5101.801 of the Revised Code.

In accordance with criteria the department develops, the department may solicit proposals for entities seeking to enter into an agreement with the department under division (B)(2) of section 5101.801 of the Revised Code. The department may enter into such agreements with entities that do both of the following:

(1) Meet the proposals' criteria;

(2) If the entity's proposed project does not potentially affect persons in each county of the state, provides the department evidence that the entity has notified, in writing, the county department of job and family services of each county where persons may be affected by the implementation of the project.

(B) In developing the criteria, soliciting the proposals, and entering in the agreements, the department shall comply with all applicable federal and state laws, the Title IV-A state plan submitted to the United States secretary of health and human services under section 5101.80 of the Revised Code, amendments to the Title IV-A state plan submitted to the United States secretary under that section, and federal waivers the United States secretary grants.

(C) The department shall begin implementation of the Title IV-A demonstration program no later than January 1, 2006.

Sec. 5101.821. Except as otherwise approved by the director of budget and management, the department of job and family services shall deposit federal funds received under Title IV-A of the "Social Security Act," 42 U.S.C.A. 601, 110 Stat. 2113 (1996), into the temporary assistance for needy families (TANF) federal fund, which is hereby created in the state treasury. The department shall use money in the fund for the Ohio works first program established under Chapter 5107. of the Revised Code; the prevention, retention, and contingency program established under Chapter 5108. of the Revised Code; social services provided pursuant to section 5101.461 of the Revised Code; and any other purposes consistent with Title IV-A, federal regulations, federal waivers granted by the United States secretary of health and human services, state law, the Title IV-A state plan and amendments submitted to the United States secretary of health and human services under section 5101.80 of the Revised Code, and rules adopted by the department under section 5107.05 of the Revised Code.

Sec. 5101.93. (A) The director of job and family services shall determine whether a waiver of federal medicaid requirements is necessary to

fulfill the requirements of section 3901.3814 of the Revised Code. If the director determines a waiver is necessary, the department of job and family services shall apply to the United States secretary of health and human services for the waiver.

(B)(1) If the director determines that section 3901.3814 of the Revised Code can be implemented without a waiver or a waiver is granted, the department shall notify the department of insurance that the section can be implemented. Implementation of the section shall be effective eighteen months after the notice is sent.

(2) At the time the notice is given under division (B)(1) of this section, the department shall also give notice to each health insuring corporation that provides coverage to medicaid recipients. The notice shall inform the corporation that sections 3901.38 and 3901.381 to 3901.3814 of the Revised Code apply to claims for services rendered to recipients on the date determined under division (B)(1) of this section. That date shall be specified in the notice.

Sec. 5101.98. (A) There is hereby created in the state treasury the military injury relief fund, which shall consist of money contributed to it under section 5747.113 of the Revised Code and of contributions made directly to it. Any person may contribute directly to the fund in addition to or independently of the income tax refund contribution system established in section 5747.113 of the Revised Code.

(B) Upon application, the director of job and family services shall grant money in the fund to individuals injured while in active service as a member of the armed forces of the United States and while serving under operation Iraqi freedom or operation enduring freedom.

(C) An individual who receives a grant under this section is not precluded from receiving one or more additional grants under this section and is not precluded from being considered for or receiving other assistance offered by the department of job and family services.

(D) The director shall adopt rules under Chapter 119. of the Revised Code establishing:

(1) Forms and procedures by which individuals may apply for a grant under this section;

(2) Criteria for reviewing, evaluating, and ranking grant applications;

(3) Criteria for determining the amount of grants awarded under this section; and

(4) Any other rules necessary to administer the grant program established in this section.

Sec. 5104.01. As used in this chapter:

(A) "Administrator" means the person responsible for the daily operation of a center or type A home. The administrator and the owner may be the same person.

(B) "Approved child day camp" means a child day camp approved pursuant to section 5104.22 of the Revised Code.

(C) "Authorized provider" means a person authorized by a county director of job and family services to operate a certified type B family day-care home.

(D) "Border state child care provider" means a child care provider that is located in a state bordering Ohio and that is licensed, certified, or otherwise approved by that state to provide child care.

(E) "Caretaker parent" means the father or mother of a child whose presence in the home is needed as the caretaker of the child, a person who has legal custody of a child and whose presence in the home is needed as the caretaker of the child, a guardian of a child whose presence in the home is needed as the caretaker of the child, and any other person who stands in loco parentis with respect to the child and whose presence in the home is needed as the caretaker of the child.

(F) "Certified type B family day-care home" and "certified type B home" mean a type B family day-care home that is certified by the director of the county department of job and family services pursuant to section 5104.11 of the Revised Code to receive public funds for providing child care pursuant to this chapter and any rules adopted under it.

(G) "Chartered nonpublic school" means a school that meets standards for nonpublic schools prescribed by the state board of education for nonpublic schools pursuant to section 3301.07 of the Revised Code.

(H) "Child" includes an infant, toddler, preschool child, or school child.

(I) "Child care block grant act" means the "Child Care and Development Block Grant Act of 1990," established in section 5082 of the "Omnibus Budget Reconciliation Act of 1990," 104 Stat. 1388-236 (1990), 42 U.S.C. 9858, as amended.

(J) "Child day camp" means a program in which only school children attend or participate, that operates for no more than seven hours per day, that operates only during one or more public school district's regular vacation periods or for no more than fifteen weeks during the summer, and that operates outdoor activities for each child who attends or participates in the program for a minimum of fifty per cent of each day that children attend or participate in the program, except for any day when hazardous weather conditions prevent the program from operating outdoor activities for a minimum of fifty per cent of that day. For purposes of this division, the

maximum seven hours of operation time does not include transportation time from a child's home to a child day camp and from a child day camp to a child's home.

(K) "Child care" means administering to the needs of infants, toddlers, preschool children, and school children outside of school hours by persons other than their parents or guardians, custodians, or relatives by blood, marriage, or adoption for any part of the twenty-four-hour day in a place or residence other than a child's own home.

(L) "Child day-care center" and "center" mean any place in which child care or publicly funded child care is provided for thirteen or more children at one time or any place that is not the permanent residence of the licensee or administrator in which child care or publicly funded child care is provided for seven to twelve children at one time. In counting children for the purposes of this division, any children under six years of age who are related to a licensee, administrator, or employee and who are on the premises of the center shall be counted. "Child day-care center" and "center" do not include any of the following:

(1) A place located in and operated by a hospital, as defined in section 3727.01 of the Revised Code, in which the needs of children are administered to, if all the children whose needs are being administered to are monitored under the on-site supervision of a physician licensed under Chapter 4731. of the Revised Code or a registered nurse licensed under Chapter 4723. of the Revised Code, and the services are provided only for children who, in the opinion of the child's parent, guardian, or custodian, are exhibiting symptoms of a communicable disease or other illness or are injured;

(2) A child day camp;

(3) A place that provides child care, but not publicly funded child care, if all of the following apply:

(a) An organized religious body provides the child care;

(b) A parent, custodian, or guardian of at least one child receiving child care is on the premises and readily accessible at all times;

(c) The child care is not provided for more than thirty days a year;

(d) The child care is provided only for preschool and school children.

(M) "Child care resource and referral service organization" means a community-based nonprofit organization that provides child care resource and referral services but not child care.

(N) "Child care resource and referral services" means all of the following services:

(1) Maintenance of a uniform data base of all child care providers in the

community that are in compliance with this chapter, including current occupancy and vacancy data;

(2) Provision of individualized consumer education to families seeking child care;

(3) Provision of timely referrals of available child care providers to families seeking child care;

(4) Recruitment of child care providers;

(5) Assistance in the development, conduct, and dissemination of training for child care providers and provision of technical assistance to current and potential child care providers, employers, and the community;

(6) Collection and analysis of data on the supply of and demand for child care in the community;

(7) Technical assistance concerning locally, state, and federally funded child care and early childhood education programs;

(8) Stimulation of employer involvement in making child care more affordable, more available, safer, and of higher quality for their employees and for the community;

(9) Provision of written educational materials to caretaker parents and informational resources to child care providers;

(10) Coordination of services among child care resource and referral service organizations to assist in developing and maintaining a statewide system of child care resource and referral services if required by the department of job and family services;

(11) Cooperation with the county department of job and family services in encouraging the establishment of parent cooperative child care centers and parent cooperative type A family day-care homes.

(O) "Child-care staff member" means an employee of a child day-care center or type A family day-care home who is primarily responsible for the care and supervision of children. The administrator may be a part-time child-care staff member when not involved in other duties.

(P) "Drop-in child day-care center," "drop-in center," "drop-in type A family day-care home," and "drop-in type A home" mean a center or type A home that provides child care or publicly funded child care for children on a temporary, irregular basis.

(Q) "Employee" means a person who either:

(1) Receives compensation for duties performed in a child day-care center or type A family day-care home;

(2) Is assigned specific working hours or duties in a child day-care center or type A family day-care home.

(R) "Employer" means a person, firm, institution, organization, or

agency that operates a child day-care center or type A family day-care home subject to licensure under this chapter.

(S) "Federal poverty line" means the official poverty guideline as revised annually in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902, as amended, for a family size equal to the size of the family of the person whose income is being determined.

(T) "Head start program" means a comprehensive child development program that receives funds distributed under the "Head Start Act," 95 Stat. 499 (1981), 42 U.S.C.A. 9831, as amended, ~~or under sections 3301.31 to 3301.37 of the Revised Code~~ and is licensed as a child day-care center.

(U) "Income" means gross income, as defined in section 5107.10 of the Revised Code, less any amounts required by federal statutes or regulations to be disregarded.

(V) "Indicator checklist" means an inspection tool, used in conjunction with an instrument-based program monitoring information system, that contains selected licensing requirements that are statistically reliable indicators or predictors of a child day-care center or type A family day-care home's compliance with licensing requirements.

(W) "Infant" means a child who is less than eighteen months of age.

(X) "In-home aide" means a person certified by a county director of job and family services pursuant to section 5104.12 of the Revised Code to provide publicly funded child care to a child in a child's own home pursuant to this chapter and any rules adopted under it.

(Y) "Instrument-based program monitoring information system" means a method to assess compliance with licensing requirements for child day-care centers and type A family day-care homes in which each licensing requirement is assigned a weight indicative of the relative importance of the requirement to the health, growth, and safety of the children that is used to develop an indicator checklist.

(Z) "License capacity" means the maximum number in each age category of children who may be cared for in a child day-care center or type A family day-care home at one time as determined by the director of job and family services considering building occupancy limits established by the department of commerce, number of available child-care staff members, amount of available indoor floor space and outdoor play space, and amount of available play equipment, materials, and supplies.

(AA) "Licensed preschool program" or "licensed school child program" means a preschool program or school child program, as defined in section 3301.52 of the Revised Code, that is licensed by the department of

education pursuant to sections 3301.52 to 3301.59 of the Revised Code.

(BB) "Licensee" means the owner of a child day-care center or type A family day-care home that is licensed pursuant to this chapter and who is responsible for ensuring its compliance with this chapter and rules adopted pursuant to this chapter.

(CC) "Operate a child day camp" means to operate, establish, manage, conduct, or maintain a child day camp.

(DD) "Owner" includes a person, as defined in section 1.59 of the Revised Code, or government entity.

(EE) "Parent cooperative child day-care center," "parent cooperative center," "parent cooperative type A family day-care home," and "parent cooperative type A home" mean a corporation or association organized for providing educational services to the children of members of the corporation or association, without gain to the corporation or association as an entity, in which the services of the corporation or association are provided only to children of the members of the corporation or association, ownership and control of the corporation or association rests solely with the members of the corporation or association, and at least one parent-member of the corporation or association is on the premises of the center or type A home during its hours of operation.

(FF) "Part-time child day-care center," "part-time center," "part-time type A family day-care home," and "part-time type A home" mean a center or type A home that provides child care or publicly funded child care for no more than four hours a day for any child.

(GG) "Place of worship" means a building where activities of an organized religious group are conducted and includes the grounds and any other buildings on the grounds used for such activities.

(HH) "Preschool child" means a child who is three years old or older but is not a school child.

(II) "Protective child care" means publicly funded child care for the direct care and protection of a child to whom either of the following applies:

(1) A case plan prepared and maintained for the child pursuant to section 2151.412 of the Revised Code indicates a need for protective care and the child resides with a parent, stepparent, guardian, or another person who stands in loco parentis as defined in rules adopted under section 5104.38 of the Revised Code;

(2) The child and the child's caretaker either temporarily reside in a facility providing emergency shelter for homeless families or are determined by the county department of job and family services to be homeless, and are otherwise ineligible for publicly funded child care.

(JJ) "Publicly funded child care" means administering to the needs of infants, toddlers, preschool children, and school children under age thirteen during any part of the twenty-four-hour day by persons other than their caretaker parents for remuneration wholly or in part with federal or state funds, including funds available under the child care block grant act, Title IV-A, and Title XX, distributed by the department of job and family services.

(KK) "Religious activities" means any of the following: worship or other religious services; religious instruction; Sunday school classes or other religious classes conducted during or prior to worship or other religious services; youth or adult fellowship activities; choir or other musical group practices or programs; meals; festivals; or meetings conducted by an organized religious group.

(LL) "School child" means a child who is enrolled in or is eligible to be enrolled in a grade of kindergarten or above but is less than fifteen years old.

(MM) "School child day-care center," "school child center," "school child type A family day-care home," and "school child type A family home" mean a center or type A home that provides child care for school children only and that does either or both of the following:

(1) Operates only during that part of the day that immediately precedes or follows the public school day of the school district in which the center or type A home is located;

(2) Operates only when the public schools in the school district in which the center or type A home is located are not open for instruction with pupils in attendance.

(NN) "State median income" means the state median income calculated by the department of development pursuant to division (A)(1)(g) of section 5709.61 of the Revised Code.

(OO) "Title IV-A" means Title IV-A of the "Social Security Act," 110 Stat. 2113 (1996), 42 U.S.C. 601, as amended.

(PP) "Title XX" means Title XX of the "Social Security Act," 88 Stat. 2337 (1974), 42 U.S.C. 1397, as amended.

(QQ) "Toddler" means a child who is at least eighteen months of age but less than three years of age.

(RR) "Type A family day-care home" and "type A home" mean a permanent residence of the administrator in which child care or publicly funded child care is provided for seven to twelve children at one time or a permanent residence of the administrator in which child care is provided for four to twelve children at one time if four or more children at one time are under two years of age. In counting children for the purposes of this

division, any children under six years of age who are related to a licensee, administrator, or employee and who are on the premises of the type A home shall be counted. "Type A family day-care home" does not include a residence in which the needs of children are administered to, if all of the children whose needs are being administered to are siblings of the same immediate family and the residence is the home of the siblings. "Type A family day-care home" and "type A home" do not include any child day camp.

(SS) "Type B family day-care home" and "type B home" mean a permanent residence of the provider in which child care is provided for one to six children at one time and in which no more than three children are under two years of age at one time. In counting children for the purposes of this division, any children under six years of age who are related to the provider and who are on the premises of the type B home shall be counted. "Type B family day-care home" does not include a residence in which the needs of children are administered to, if all of the children whose needs are being administered to are siblings of the same immediate family and the residence is the home of the siblings. "Type B family day-care home" and "type B home" do not include any child day camp.

Sec. 5104.02. (A) The director of job and family services is responsible for the licensing of child day-care centers and type A family day-care homes~~, and~~. Each entity operating a head start program shall meet the criteria for, and be licensed as, a child day-care center. The director is responsible for the enforcement of this chapter and of rules promulgated pursuant to this chapter. ~~No~~

No person, firm, organization, institution, or agency shall operate, establish, manage, conduct, or maintain a child day-care center or type A family day-care home without a license issued under section 5104.03 of the Revised Code. The current license shall be posted in a conspicuous place in the center or type A home that is accessible to parents, custodians, or guardians and employees of the center or type A home at all times when the center or type A home is in operation.

(B) A person, firm, institution, organization, or agency operating any of the following programs is exempt from the requirements of this chapter:

(1) A program of child care that operates for two or less consecutive weeks;

(2) Child care in places of worship during religious activities during which children are cared for while at least one parent, guardian, or custodian of each child is participating in such activities and is readily available;

(3) Religious activities which do not provide child care;

(4) Supervised training, instruction, or activities of children in specific areas, including, but not limited to: art; drama; dance; music; gymnastics, swimming, or another athletic skill or sport; computers; or an educational subject conducted on an organized or periodic basis no more than one day a week and for no more than six hours duration;

(5) Programs in which the director determines that at least one parent, custodian, or guardian of each child is on the premises of the facility offering child care and is readily accessible at all times, except that child care provided on the premises at which a parent, custodian, or guardian is employed more than two and one-half hours a day shall be licensed in accordance with division (A) of this section;

(6)(a) Programs that provide child care funded and regulated or operated and regulated by state departments other than the department of job and family services or the state board of education when the director of job and family services has determined that the rules governing the program are equivalent to or exceed the rules promulgated pursuant to this chapter.

Notwithstanding any exemption from regulation under this chapter, each state department shall submit to the director of job and family services a copy of the rules that govern programs that provide child care and are regulated or operated and regulated by the department. Annually, each state department shall submit to the director a report for each such program it regulates or operates and regulates that includes the following information:

(i) The site location of the program;

(ii) The maximum number of infants, toddlers, preschool children, or school children served by the program at one time;

(iii) The number of adults providing child care for the number of infants, toddlers, preschool children, or school children;

(iv) Any changes in the rules made subsequent to the time when the rules were initially submitted to the director.

The director shall maintain a record of the child care information submitted by other state departments and shall provide this information upon request to the general assembly or the public.

(b) Child care programs conducted by boards of education or by chartered nonpublic schools that are conducted in school buildings and that provide child care to school children only shall be exempt from meeting or exceeding rules promulgated pursuant to this chapter.

(7) Any preschool program or school child program, except a head start program, that is subject to licensure by the department of education under sections 3301.52 to 3301.59 of the Revised Code.

(8) Any program providing child care that meets all of the following

requirements and, on October 20, 1987, was being operated by a nonpublic school that holds a charter issued by the state board of education for kindergarten only:

(a) The nonpublic school has given the notice to the state board and the director of job and family services required by Section 4 of Substitute House Bill No. 253 of the 117th general assembly;

(b) The nonpublic school continues to be chartered by the state board for kindergarten, or receives and continues to hold a charter from the state board for kindergarten through grade five;

(c) The program is conducted in a school building;

(d) The program is operated in accordance with rules promulgated by the state board under sections 3301.52 to 3301.57 of the Revised Code.

(9) A youth development program operated outside of school hours by a community-based center to which all of the following apply:

(a) The children enrolled in the program are under nineteen years of age and enrolled in or eligible to be enrolled in a grade of kindergarten or above.

(b) The program provides informal child care and at least two of the following supervised activities: educational, recreational, culturally enriching, social, and personal development activities.

(c) The state board of education has approved the program's participation in the child and adult care food program as an outside-school-hours care center pursuant to standards established under section 3313.813 of the Revised Code.

(d) The community-based center operating the program is exempt from federal income taxation pursuant to 26 U.S.C. 501(a) and (c)(3).

Sec. 5104.32. (A) Except as provided in division (C) of this section, all purchases of publicly funded child care shall be made under a contract entered into by a licensed child day-care center, licensed type A family day-care home, certified type B family day-care home, certified in-home aide, approved child day camp, licensed preschool program, licensed school child program, or border state child care provider and the county department of job and family services. A county department of job and family services may enter into a contract with a provider for publicly funded child care for a specified period of time or upon a continuous basis for an unspecified period of time. All contracts for publicly funded child care shall be contingent upon the availability of state and federal funds. The department of job and family services shall prescribe a standard form to be used for all contracts for the purchase of publicly funded child care, regardless of the source of public funds used to purchase the child care. To the extent permitted by federal law and notwithstanding any other provision of the Revised Code that regulates

state or county contracts or contracts involving the expenditure of state, county, or federal funds, all contracts for publicly funded child care shall be entered into in accordance with the provisions of this chapter and are exempt from any other provision of the Revised Code that regulates state or county contracts or contracts involving the expenditure of state, county, or federal funds.

(B) Each contract for publicly funded child care shall specify at least the following:

(1) That the provider of publicly funded child care agrees to be paid for rendering services at the lowest of the rate customarily charged by the provider for children enrolled for child care, the reimbursement ceiling or rate of payment established pursuant to section 5104.30 of the Revised Code, or a rate the county department negotiates with the provider;

(2) That, if a provider provides child care to an individual potentially eligible for publicly funded child care who is subsequently determined to be eligible, the county department agrees to pay for all child care provided between the date the county department receives the individual's completed application and the date the individual's eligibility is determined;

(3) Whether the county department of job and family services, the provider, or a child care resource and referral service organization will make eligibility determinations, whether the provider or a child care resource and referral service organization will be required to collect information to be used by the county department to make eligibility determinations, and the time period within which the provider or child care resource and referral service organization is required to complete required eligibility determinations or to transmit to the county department any information collected for the purpose of making eligibility determinations;

(4) That the provider, other than a border state child care provider ~~or except as provided in division (B) of section 3301.37 of the Revised Code~~, shall continue to be licensed, approved, or certified pursuant to this chapter and shall comply with all standards and other requirements in this chapter and in rules adopted pursuant to this chapter for maintaining the provider's license, approval, or certification;

(5) That, in the case of a border state child care provider, the provider shall continue to be licensed, certified, or otherwise approved by the state in which the provider is located and shall comply with all standards and other requirements established by that state for maintaining the provider's license, certificate, or other approval;

(6) Whether the provider will be paid by the county department of job and family services or the state department of job and family services;

(7) That the contract is subject to the availability of state and federal funds.

(C) Unless specifically prohibited by federal law, the county department of job and family services shall give individuals eligible for publicly funded child care the option of obtaining certificates for payment that the individual may use to purchase services from any provider qualified to provide publicly funded child care under section 5104.31 of the Revised Code. Providers of publicly funded child care may present these certificates for payment for reimbursement in accordance with rules that the director of job and family services shall adopt. Only providers may receive reimbursement for certificates for payment. The value of the certificate for payment shall be based on the lowest of the rate customarily charged by the provider, the reimbursement ceiling or rate of payment established pursuant to section 5104.30 of the Revised Code, or a rate the county department negotiates with the provider. The county department may provide the certificates for payment to the individuals or may contract with child care providers or child care resource and referral service organizations that make determinations of eligibility for publicly funded child care pursuant to contracts entered into under section 5104.34 of the Revised Code for the providers or resource and referral service organizations to provide the certificates for payment to individuals whom they determine are eligible for publicly funded child care.

For each six-month period a provider of publicly funded child care provides publicly funded child day-care to the child of an individual given certificates for payment, the individual shall provide the provider certificates for days the provider would have provided publicly funded child care to the child had the child been present. County departments shall specify the maximum number of days providers will be provided certificates of payment for days the provider would have provided publicly funded child care had the child been present. The maximum number of days shall not exceed ten days in a six-month period during which publicly funded child care is provided to the child regardless of the number of providers that provide publicly funded child care to the child during that period.

Sec. 5107.05. The director of job and family services shall adopt rules to implement this chapter. The rules shall be consistent with Title IV-A, Title IV-D, federal regulations, state law, the Title IV-A state plan submitted to the United States secretary of health and human services under section 5101.80 of the Revised Code, amendments to the plan, and waivers granted by the United States secretary. Rules governing eligibility, program participation, and other applicant and participant requirements shall be adopted in accordance with Chapter 119. of the Revised Code. Rules

governing financial and other administrative requirements applicable to the department of job and family services and county departments of job and family services shall be adopted in accordance with section 111.15 of the Revised Code.

(A) The rules shall specify, establish, or govern all of the following:

(1) A payment standard for Ohio works first based on federal and state appropriations;

(2) The method of determining the amount of cash assistance an assistance group receives under Ohio works first;

(3) Requirements for initial and continued eligibility for Ohio works first, including requirements regarding income, citizenship, age, residence, and assistance group composition. The rules regarding income shall specify what is countable income, gross earned income, and gross unearned income for the purpose of section 5107.10 of the Revised Code.

(4) For the purpose of section 5107.12 of the Revised Code, application and verification procedures, including the minimum information an application must contain;

(5) The extent to which a participant of Ohio works first must notify, pursuant to section 5107.12 of the Revised Code, a county department of job and family services of additional income not previously reported to the county department;

(6) The department of job and family services providing written notice of a sanction under section 5107.161 of the Revised Code;

(7) Requirements for the collection and distribution of support payments owed participants of Ohio works first pursuant to section 5107.20 of the Revised Code;

(8) For the purpose of section 5107.22 of the Revised Code, what constitutes cooperating in establishing a minor child's paternity or establishing, modifying, or enforcing a child support order and good cause for failure or refusal to cooperate. The rule shall be consistent with 42 U.S.C.A. 654(29).

(9) The ~~administration of~~ requirements governing the LEAP program provided for under section 5107.30 of the Revised Code, including the definitions of "equivalent of a high school diploma" and "good cause," and the incentives provided under the LEAP program;

(10) If the director implements section 5107.301 of the Revised Code, the requirements governing the award provided under that section, including the form that the award is to take and requirements an individual must satisfy to receive the award;

(11) Circumstances under which a county department of job and family

services may exempt a minor head of household or adult from participating in a work activity or developmental activity for all or some of the weekly hours otherwise required by section 5107.43 of the Revised Code. Circumstances shall include that a school or place of work is closed due to a holiday or weather or other emergency and that an employer grants the minor head of household or adult leave for illness or earned vacation.

~~(11)~~(12) The maximum amount of time the department will subsidize positions created by state agencies and political subdivisions under division (C) of section 5107.52 of the Revised Code.

(B) The rules may provide that a county department of job and family services is not required to take action under section 5107.76 of the Revised Code to recover an erroneous payment that is below an amount the department specifies.

Sec. 5107.10. (A) As used in this section:

(1) "Countable income," "gross earned income," and "gross unearned income" have the meanings established in rules adopted under section 5107.05 of the Revised Code.

(2) "Federal poverty guidelines" has the same meaning as in section 5101.46 of the Revised Code, except that references to a person's family in the definition shall be deemed to be references to the person's assistance group.

(3) "Gross income" means gross earned income and gross unearned income.

~~(3)~~(4) "Initial eligibility threshold" means the higher of the following:

(a) Fifty per cent of the federal poverty guidelines;

(b) The gross income maximum for initial eligibility for Ohio works first as that maximum was set by division (D)(1)(a) of this section on the day before the effective date of this amendment.

(5) "Strike" means continuous concerted action in failing to report to duty; willful absence from one's position; or stoppage of work in whole from the full, faithful, and proper performance of the duties of employment, for the purpose of inducing, influencing, or coercing a change in wages, hours, terms, and other conditions of employment. "Strike" does not include a stoppage of work by employees in good faith because of dangerous or unhealthful working conditions at the place of employment that are abnormal to the place of employment.

(B) Under the Ohio works first program, an assistance group shall receive, except as otherwise provided by this chapter, time-limited cash assistance. In the case of an assistance group that includes a minor head of household or adult, assistance shall be provided in accordance with the

self-sufficiency contract entered into under section 5107.14 of the Revised Code.

(C) To be eligible to participate in Ohio works first, an assistance group must meet all of the following requirements:

(1) The assistance group, except as provided in division (E) of this section, must include at least one of the following:

(a) A minor child who, except as provided in section 5107.24 of the Revised Code, resides with a parent, or specified relative caring for the child, or, to the extent permitted by Title IV-A and federal regulations adopted until Title IV-A, resides with a guardian or custodian caring for the child;

(b) A parent residing with and caring for the parent's minor child who receives supplemental security income under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended, or federal, state, or local adoption assistance;

(c) A specified relative residing with and caring for a minor child who is related to the specified relative in a manner that makes the specified relative a specified relative and receives supplemental security income or federal, state, or local foster care or adoption assistance;

(d) A woman at least six months pregnant.

(2) The assistance group must meet the income requirements established by division (D) of this section.

(3) No member of the assistance group may be involved in a strike.

(4) The assistance group must satisfy the requirements for Ohio works first established by this chapter and sections 5101.58, 5101.59, and 5101.83 of the Revised Code.

(5) The assistance group must meet requirements for Ohio works first established by rules adopted under section 5107.05 of the Revised Code.

(D)(1) Except as provided in division (D)~~(3)~~(4) of this section, to determine whether an assistance group is initially eligible to participate in Ohio works first, a county department of job and family services shall do the following:

(a) Determine whether the assistance group's gross income exceeds the ~~following amount:~~

| ~~Size of Assistance Group~~ | ~~Gross Income~~ |
|---|---|
| ~~1~~ | ~~$423~~ |
| ~~2~~ | ~~$537~~ |
| ~~3~~ | ~~$630~~ |
| ~~4~~ | ~~$750~~ |
| ~~5~~ | ~~$858~~ |

| | |
|---|---|
| ~~6~~ | ~~$942~~ |
| ~~7~~ | ~~$1,038~~ |
| ~~8~~ | ~~$1,139~~ |
| ~~9~~ | ~~$1,241~~ |
| ~~10~~ | ~~$1,343~~ |
| ~~11~~ | ~~$1,440~~ |
| ~~12~~ | ~~$1,542~~ |
| ~~13~~ | ~~$1,643~~ |
| ~~14~~ | ~~$1,742~~ |
| ~~15~~ | ~~$1,844~~ |

~~For each person in the assistance group that brings the assistance group to more than fifteen persons, add one hundred two dollars to the amount of gross income for an assistance group of fifteen specified in division (D)(1)(a) of this section.~~

~~In~~ initial eligibility threshold. In making this determination, the county department shall disregard amounts that federal statutes or regulations and sections 5101.17 and 5117.10 of the Revised Code require be disregarded. The assistance group is ineligible to participate in Ohio works first if the assistance group's gross income, less the amounts disregarded, exceeds the ~~amount specified in division (D)(1)(a) of this section~~ initial eligibility threshold.

(b) If the assistance group's gross income, less the amounts disregarded pursuant to division (D)(1)(a) of this section, does not exceed the ~~amount specified in that division~~ initial eligibility threshold, determine whether the assistance group's countable income is less than the payment standard. The assistance group is ineligible to participate in Ohio works first if the assistance group's countable income equals or exceeds the payment standard.

(2) For the purpose of determining whether an assistance group meets the income requirement established by division (D)(1)(a) of this section, the annual revision that the United States department of health and human services makes to the federal poverty guidelines shall go into effect on the first day of July of the year for which the revision is made.

(3) To determine whether an assistance group participating in Ohio works first continues to be eligible to participate, a county department of job and family services shall determine whether the assistance group's countable income continues to be less than the payment standard. In making this determination, the county department shall disregard the first two hundred fifty dollars and fifty per cent of the remainder of the assistance group's gross earned income. No amounts shall be disregarded from the assistance

group's gross unearned income. The assistance group ceases to be eligible to participate in Ohio works first if its countable income, less the amounts disregarded, equals or exceeds the payment standard.

~~(3)~~(4) If an assistance group reapplies to participate in Ohio works first not more than four months after ceasing to participate, a county department of job and family services shall use the income requirement established by division (D)~~(2)~~(3) of this section to determine eligibility for resumed participation rather than the income requirement established by division (D)(1) of this section.

(E)(1) An assistance group may continue to participate in Ohio works first even though a public children services agency removes the assistance group's minor children from the assistance group's home due to abuse, neglect, or dependency if the agency does both of the following:

(a) Notifies the county department of job and family services at the time the agency removes the children that it believes the children will be able to return to the assistance group within six months;

(b) Informs the county department at the end of each of the first five months after the agency removes the children that the parent, guardian, custodian, or specified relative of the children is cooperating with the case plans prepared for the children under section 2151.412 of the Revised Code and that the agency is making reasonable efforts to return the children to the assistance group.

(2) An assistance group may continue to participate in Ohio works first pursuant to division (E)(1) of this section for not more than six payment months. This division does not affect the eligibility of an assistance group that includes a woman at least six months pregnant.

Sec. 5107.26. (A) As used in this section:

(1) "Transitional child care" means publicly funded child care provided under division (A)(3) of section 5104.34 of the Revised Code.

(2) "Transitional medicaid" means the medical assistance provided under section ~~5111.023~~ 5111.0115 of the Revised Code.

(B) Except as provided in division (C) of this section, each member of an assistance group participating in Ohio works first is ineligible to participate in the program for six payment months if a county department of job and family services determines that a member of the assistance group terminated the member's employment and each person who, on the day prior to the day a recipient begins to receive transitional child care or transitional medicaid, was a member of the recipient's assistance group is ineligible to participate in Ohio works first for six payment months if a county department determines that the recipient terminated the recipient's

employment.

(C) No assistance group member shall lose or be denied eligibility to participate in Ohio works first pursuant to division (B) of this section if the termination of employment was because an assistance group member or recipient of transitional child care or transitional medicaid secured comparable or better employment or the county department of job and family services certifies that the member or recipient terminated the employment with just cause.

Just cause includes the following:

(1) Discrimination by an employer based on age, race, sex, color, handicap, religious beliefs, or national origin;

(2) Work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule;

(3) Employment that has become unsuitable due to any of the following:

(a) The wage is less than the federal minimum wage;

(b) The work is at a site subject to a strike or lockout, unless the strike has been enjoined under section 208 of the "Labor-Management Relations Act," 61 Stat. 155 (1947), 29 U.S.C.A. 178, as amended, an injunction has been issued under section 10 of the "Railway Labor Act," 44 Stat. 586 (1926), 45 U.S.C.A. 160, as amended, or an injunction has been issued under section 4117.16 of the Revised Code;

(c) The documented degree of risk to the member or recipient's health and safety is unreasonable;

(d) The member or recipient is physically or mentally unfit to perform the employment, as documented by medical evidence or by reliable information from other sources.

(4) Documented illness of the member or recipient or of another assistance group member of the member or recipient requiring the presence of the member or recipient;

(5) A documented household emergency;

(6) Lack of adequate child care for children of the member or recipient who are under six years of age.

Sec. 5107.30. (A) As used in this section:

(1) "Equivalent of a high school diploma" and "good cause" have the meanings established in rules adopted under section 5107.05 of the Revised Code.

(2) "LEAP program" means the learning, earning, and parenting program.

~~(2) "Teen"~~ (3) "Participating teen" means an individual to whom all of the following apply:

(a) The individual is a participant of Ohio works first ~~who~~;

(b) The individual is under age eighteen or is age eighteen and in school and is a natural or adoptive parent or is pregnant;

(c) The individual is subject to the LEAP program's requirements.

~~(3)~~(4) "School" means an educational program that is designed to lead to the attainment of a high school diploma or the equivalent of a high school diploma.

(B) The director of job and family services may ~~adopt rules under section 5107.05 of the Revised Code, to the extent that such rules are consistent with federal law, to do all of the following:~~

~~(1) Define "good cause" and "the equivalent of a high school diploma" for the purposes of this section;~~

~~(2) Conduct~~ conduct a program titled the "LEAP program" ~~and establish requirements governing the program~~ in accordance with rules adopted under section 5107.05 of the Revised Code. The purpose of the LEAP program is to encourage teens to complete school.

~~(3) Require every~~ Every participating teen ~~who is subject to LEAP program requirements to~~ shall attend school in accordance with the requirements governing the LEAP program unless the participating teen shows good cause for not attending school. The department shall provide, in addition to the cash assistance payment provided under Ohio works first, an incentive payment, in an amount determined by the department, to every participating teen who ~~is participating in the LEAP program and~~ attends school in accordance with the requirements governing the LEAP program. In addition to the incentive payment, the department may provide other incentives to participating teens who attend school in accordance with the LEAP program's requirements. The department shall reduce the cash assistance payment, in an amount determined by the department, under Ohio works first to every participating teen ~~participating in the LEAP program~~ who fails or refuses, without good cause, to meet the LEAP program's requirements ~~governing the program~~.

~~(4) Require every~~ Every participating teen ~~who is subject to LEAP program requirements to~~ shall enter into a written agreement with the county department of job and family services that ~~provides~~ specifies all of the following:

~~(a)~~(1) The participating teen, to be eligible to receive the incentive payment and other incentives, if any, under ~~division (B)(3) of~~ this section, must meet the requirements of the LEAP program.

~~(b)~~(2) The ~~county department will provide the~~ incentive payment ~~to the teen~~ and other incentives, if any, will be provided if the participating teen

meets the requirements of the LEAP program.

~~(c)~~(3) The ~~county department will reduce the~~ participating teen's cash assistance payment under Ohio works first will be reduced if the participating teen fails or refuses without good cause to attend school in accordance with the requirements governing the LEAP program.

(C) A minor head of household who is participating in the LEAP program shall be considered to be participating in a work activity for the purpose of sections 5107.40 to 5107.69 of the Revised Code. However, the minor head of household is not subject to the requirements or sanctions of those sections.

(D) Subject to the availability of funds, county departments of job and family services shall provide for ~~LEAP participants~~ participating teens to receive support services the county department determines to be necessary for LEAP participation. Support services may include publicly funded child care under Chapter 5104. of the Revised Code, transportation, and other services.

Sec. 5107.301. For the purpose of encouraging individuals who have successfully completed the requirements of the LEAP program to enroll in post-secondary education, the director of job and family services may provide an award to such individuals who enroll in post-secondary education. If provided, the award shall be provided in accordance with rules adopted under section 5107.05 of the Revised Code.

Sec. 5107.58. In accordance with a federal waiver granted by the United States secretary of health and human services pursuant to a request made under former section 5101.09 of the Revised Code, county departments of job and family services may establish and administer as a work activity for minor heads of households and adults participating in Ohio works first an education program under which the participant is enrolled full-time in post-secondary education leading to vocation at a state institution of higher education, as defined in section 3345.031 of the Revised Code; a private nonprofit college or university that possesses a certificate of authorization issued by the Ohio board of regents pursuant to Chapter 1713. of the Revised Code, or is exempted by division (E) of section 1713.02 of the Revised Code from the requirement of a certificate; a school that holds a certificate of registration and program authorization issued by the state board of career colleges and schools under Chapter 3332. of the Revised Code; a private institution exempt from regulation under Chapter 3332. of the Revised Code as prescribed in section 3333.046 of the Revised Code; or a school that has entered into a contract with the county department of job and family services. The participant shall make reasonable efforts, as

determined by the county department, to obtain a loan, scholarship, grant, or other assistance to pay for the tuition, including a federal Pell grant under 20 U.S.C.A. 1070a ~~and~~, an Ohio instructional grant under section 3333.12 of the Revised Code, and an Ohio college opportunity grant under section 3333.122 of the Revised Code. If the participant has made reasonable efforts but is unable to obtain sufficient assistance to pay the tuition the program may pay the tuition. On or after October 1, 1998, the county department may enter into a loan agreement with the participant to pay the tuition. The total period for which tuition is paid and loans made shall not exceed two years. If the participant, pursuant to division (B)(3) of section 5107.43 of the Revised Code, volunteers to participate in the education program for more hours each week than the participant is assigned to the program, the program may pay or the county department may loan the cost of the tuition for the additional voluntary hours as well as the cost of the tuition for the assigned number of hours. The participant may receive, for not more than three years, support services, including publicly funded child care under Chapter 5104. of the Revised Code and transportation, that the participant needs to participate in the program. To receive support services in the third year, the participant must be, as determined by the educational institution in which the participant is enrolled, in good standing with the institution.

A county department that provides loans under this section shall establish procedures governing loan application for and approval and administration of loans granted pursuant to this section.

Sec. 5110.01. As used in this chapter:

(A) "Administrative fee" means the amount specified in rules adopted under division (G) of section 5110.35 of the Revised Code.

(B) "Children's health insurance program" means the children's health insurance program part I and part II established under sections 5101.50 to 5101.5110 of the Revised Code.

(C) ~~"Disability medical assistance program" means the program established under section 5115.10 of the Revised Code.~~

~~(D)~~ "Medicaid" means the medical assistance program established under Chapter 5111. of the Revised Code.

~~(E)~~(D) "National drug code number" means the number registered for a drug pursuant to the listing system established by the United States food and drug administration under the "Drug Listing Act of 1972," 86 Stat. 559, 21 U.S.C. 360, as amended.

~~(F)~~(E) "Ohio's best Rx program administrator" means the entity, if any, the department of job and family services contracts with pursuant to section 5110.10 of the Revised Code to perform administrative functions of the

Ohio's best Rx program and to offer the mail order system through which Ohio's best Rx program participants may obtain drugs by mail.

~~(G)~~(F) "Ohio's best Rx program applicant" or "applicant" means an individual who signs an application for the Ohio's best Rx program and submits it to the department of job and family services, or the Ohio's best Rx program administrator, for a determination of eligibility for the program.

~~(H)~~(G) "Ohio's best Rx program participant" or "participant" means an individual determined eligible for the Ohio's best Rx program and included under a valid Ohio's best Rx program enrollment card.

~~(I)~~(H) "Ohio's best Rx program price" means the price a participating terminal distributor is to charge an Ohio's best Rx program participant for a drug included in the Ohio's best Rx program as determined under section 5110.14 of the Revised Code. "Ohio's best Rx program price" does not include either of the following:

(1) The amount of the professional fee, if any, the participating terminal distributor adds to the Ohio's best Rx program price pursuant to an agreement under section 5110.12 of the Revised Code;

(2) The amount of the administrative fee, if any, the department of job and family services reports to the participating terminal distributor under section 5110.29 of the Revised Code.

~~(J)~~(I) "Participating manufacturer" means a drug manufacturer participating in the Ohio's best Rx program pursuant to a rebate agreement.

~~(K)~~(J) "Participating terminal distributor" means a terminal distributor of dangerous drugs participating in the Ohio's best Rx program pursuant to an agreement entered into with the department of job and family services under section 5110.12 of the Revised Code.

~~(L)~~(K) "Per unit price," with regard to a state health benefit plan or state retirement system health benefit plan, means the total amount paid to a terminal distributor of dangerous drugs under a state health benefit plan or state retirement system health benefit plan for one unit of a drug covered by the plan, after the plan discounts or otherwise reduces the amount to be paid to the terminal distributor. "Per unit price" includes both of the following:

(1) The amount that the state health benefit plan or state retirement system health benefit plan, or other government entity or person authorized to make the payment on behalf of the plan, pays to the terminal distributor of dangerous drugs;

(2) The amount that the beneficiary of the state health benefit plan or state retirement system health benefit plan pays to the terminal distributor of dangerous drugs in the form of a copayment, coinsurance, or other cost-sharing charge.

~~(M)~~(L) "Per unit rebate," with regard to a state health benefit plan or state retirement system health benefit plan, means all rebates, discounts, formulary fees, administrative fees, and other allowances a drug manufacturer pays to the plan, or other government entity or person authorized to receive all or part of such payments, for a drug during a calendar year, divided by the total number of units of that drug dispensed under the plan during the same calendar year.

~~(N)~~(M) "Rebate administration percentage" means the percentage specified in rules adopted under division (K) of section 5110.35 of the Revised Code.

~~(O)~~(N) "Rebate agreement" means an agreement under section 5110.21 of the Revised Code between the department of job and family services and a drug manufacturer.

~~(P)~~(O) "State health benefit plan" means a program of health care benefits offered through the Ohio med preferred provider organization, or a successor entity selected by the state, to which either of the following apply:

(1) It is provided by a collective bargaining agreement authorized by division (A)(4) of section 4117.03 of the Revised Code.

(2) It is offered by the department of administrative services to state employees in accordance with section 124.81 or 124.82 of the Revised Code.

~~(Q)~~(P) "State retirement system" means all of the following: the public employees retirement system, state teachers retirement system, school employees retirement system, Ohio police and fire pension fund, and state highway patrol retirement system.

~~(R)~~(Q) "State retirement system health benefit plan" means a plan of health care benefits offered by a state retirement system under section 145.58, 742.45, 3307.39, 3309.69, or 5505.28 of the Revised Code.

~~(S)~~(R) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.

~~(T)~~(S) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

~~(U)~~(T) "Trade secret" has the same meaning as in section 1333.61 of the Revised Code.

~~(V)~~(U) "Usual and customary charge" means the amount a participating terminal distributor or the Ohio's best Rx program administrator charges for a drug included in the program to an individual who does not receive a discounted price for the drug pursuant to any drug discount program, including the Ohio's best Rx program, a prescription drug discount card program established under section 173.061 of the Revised Code, or a

pharmacy assistance program established by any person or government entity, and for whom no third-party payer or program funded in whole or part with state or federal funds is responsible for all or part of the cost of the drug the distributor dispenses to the individual.

Sec. 5110.05. (A) To be eligible for the Ohio's best Rx program, an individual must meet all of the following requirements at the time of application or reapplication for the program:

(1) Be a resident of this state;

(2) Have family income, as determined under rules adopted pursuant to section 5110.35 of the Revised Code, that does not exceed two hundred fifty per cent of the federal poverty guidelines, as revised annually by the United States department of health and human services in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902, as amended, or be sixty years of age or older;

(3) Not have outpatient prescription drug coverage paid for in whole or in part by any of the following:

(a) A third-party payer;

(b) The medicaid program;

(c) The children's health insurance program;

(d) ~~The disability medical assistance program;~~

~~(e)~~ Another health plan or pharmacy assistance program that uses state or federal funds to pay part or all of the cost of the individual's outpatient prescription drugs, other than a prescription drug discount card program established under section 173.061 of the Revised Code.

(4) Not have had outpatient prescription drug coverage specified in division (A)(3) of this section during any of the four months preceding the month in which the application or reapplication for the Ohio's best Rx program is made, unless any of the following applies:

(a) The individual is sixty years of age or older.

(b) The third-party payer that paid all or part of the coverage filed for bankruptcy under federal bankruptcy laws.

(c) The individual is no longer eligible for coverage provided through a retirement plan subject to protection under the "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C. 1001, as amended.

(d) The individual is no longer eligible for the medicaid program~~,~~ or children's health insurance program~~, or disability medical assistance program~~.

(B) Application and annual reapplication for the Ohio's best Rx program shall be made in accordance with rules adopted under section 5110.35 of the Revised Code on a form prescribed in those rules. An individual may apply

or reapply on behalf of the individual and the individual's spouse and children. The guardian or custodian of an individual may apply or reapply on behalf of the individual.

Sec. 5110.352. As used in this section, "medicaid dispensing fee" means the dispensing fee established under section ~~5111.08~~ 5111.071 of the Revised Code for the medicaid program.

In adopting a rule under division (F) of section 5110.35 of the Revised Code increasing the maximum amount of the professional fee participating terminal distributors may charge Ohio's best Rx program participants under section 5110.12 of the Revised Code and the Ohio's best Rx program administrator may charge under a contract entered into under section 5110.10 of the Revised Code, the department of job and family services shall review the amount of the professional fee once a year or, at the department's discretion, at more frequent intervals and shall not increase the professional fee to an amount exceeding the medicaid dispensing fee.

A participating terminal distributor and the Ohio's best Rx program administrator may charge a maximum three dollar professional fee regardless of whether the medicaid dispensing fee for that drug is less than that amount. The department, however, may not adopt a rule increasing the maximum professional fee for that drug until the medicaid dispensing fee for that drug exceeds that amount.

Sec. 5110.39. Not later than ~~April 1, 2005~~ the first day of March of each year, the department of job and family services shall do all of the following:

(A) Create a list of the twenty-five drugs most often dispensed to Ohio's best Rx program participants under the program, using data from the most recent six-month period for which the data is available;

(B) Determine the average amount that participating terminal distributors charge, on a date selected by the department, participants for each drug included on the list created under division (A) of this section;

(C) Determine, for the date selected for division (B) of this section, the average usual and customary charge of participating terminal distributors for each drug included on the list created under division (A) of this section;

(D) By comparing the average charges determined under divisions (B) and (C) of this section, determine the average percentage savings in the amount participating terminal distributors charge Ohio's best Rx program participants for each drug included on the list created under division (A) of this section.

Sec. 5111.011. (A) As used in this section:

(1) "Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code.

(2) "Nursing facility" ~~means a facility defined as a nursing facility under Sec. 1919 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 1396r, as amended~~ has the same meaning as in section 5111.20 of the Revised Code.

~~(2)~~(3) "Institutionalized individual" means an individual who is a patient in a nursing facility or who receives home and community-based services under a federal waiver granted the department of job and family services under 42 U.S.C. 1396a(10)(A)(ii)(VI).

(B) Subject to this section, the director of job and family services shall, pursuant to section 111.15 of the Revised Code, adopt rules establishing eligibility requirements for the ~~medical assistance~~ medicaid program and defining, consistent with federal law, the term "resources" as used in this section.

(C) In determining eligibility for ~~medical assistance~~ the medicaid program, the following shall apply with respect to real property used by an aged, blind or disabled applicant or recipient as a homestead or principal place of residence:

(1) The value of ~~real~~ the property ~~of aged, blind, or disabled persons used as a homestead by such persons~~ shall be the maximum allowed under Title XVI of the "Social Security Act~~."~~," 86 Stat. 1329 (1972), 42 U.S.C. 1381;

(2) Except as provided in division (C)(3) of this section, the department of job and family services may consider the property to not be the homestead or principal place of residence of the applicant or recipient if the applicant or recipient resides in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution for thirteen months or longer.

(3) Division (C)(2) of this section does not apply if any of the following individuals reside in the applicant's or recipient's real property used as a homestead or principal place of residence:

(a) The applicant's or recipient's spouse;

(b) A son or daughter of the applicant or recipient, if the son or daughter is under twenty-one years of age or blind or disabled in accordance with rules adopted by the director of job and family services;

(c) A son or daughter of the applicant or recipient, if the son or daughter is financially dependent on the applicant or recipient for housing in accordance with rules adopted by the director of job and family services;

(d) A sibling of the applicant or recipient, if the sibling has a verified equity and ownership interest in the real property and has resided in the real property for at least one year immediately before the date the applicant or

recipient was admitted to the nursing facility, intermediate care facility for the mentally retarded, or other medical institution.

(D) Except as provided in division (G) of this section, no person is eligible for ~~medical assistance~~ the medicaid program if on or prior to December 31, 1989, the person has transferred real or personal property for the purpose of securing ~~medical assistance under section 5111.01 of the Revised Code~~ medicaid eligibility and the transfer occurred during the two years preceding the person's application. In order to secure compliance with this division, the director of job and family services shall require all applicants for ~~assistance~~ medicaid to submit true and correct copies of any federal income or gift tax form or schedule filed, singly or jointly, by the applicant during the preceding five taxable years. Such copies, and the information disclosed thereon, shall be used solely for the purpose of determining the probability of whether the applicant has transferred assets in violation of this division. The director shall provide for the confidentiality and return of any copies of forms or schedules submitted under this division. Where such copies reveal the probability that an applicant has transferred assets in violation of this division, a presumption arises that the applicant has transferred assets in violation of this division, and the director shall deny the application until the applicant submits a true and accurate expenditure statement to the director that shows the applicant did not violate this division. The director of job and family services shall adopt rules to implement this provision.

(E)(1) Except as provided in ~~division~~ divisions (E)(2) and (G) of this section, an institutionalized individual who is otherwise eligible for ~~medical assistance~~ medicaid shall be ineligible for nursing facility services or services provided under a home and community-based waiver for a period specified in rules adopted under division (E)~~(2)~~(3) of this section if the institutionalized individual or individual's spouse, on or after January 1, 1990, transfers resources for less than fair market value at any time during or after ~~a period of time, as specified in rules adopted under division (E)(2) of this section,~~ the five-year period immediately prior to either of the following:

(a) The date the individual becomes an institutionalized individual if the individual is eligible for ~~medical assistance~~ medicaid on that date;

(b) The date the individual applies for ~~medical assistance~~ medicaid while an institutionalized individual.

(2) The director shall apply to the United States secretary of health and human services for a waiver of federal law governing the medicaid program as necessary for the implementation of the five-year look-back period

provided for by division (E)(1) of this section. If a waiver is not approved, the look-back period shall be the period of time specified in 42 U.S.C. 1396p(c).

(3) The director shall adopt rules specifying, for the purpose of division (E)(1) of this section, the ~~period of time preceding institutionalization or application for medical assistance during which transfers of assets for less than fair market value are prohibited and the~~ length of the ~~resulting~~ period of ineligibility due to transfers of resources for less than fair market value on or after the look-back date. The period of ineligibility shall begin with the month in which the resources were transferred. The rules shall be consistent with Title XIX of the "Social Security Act~~.~~," 79 Stat. 286 (1965), 42 U.S.C. 1396. The department shall allow exceptions to the period of ineligibility to the extent that exceptions are permitted by that title. An exception based on undue hardship to the institutionalized individual shall be allowed only so long as the individual cooperates with the department or the county department of job and family services in securing the return of transferred resources.

~~(3)~~(4) To secure compliance with this division, the department may require applicants for and recipients of ~~medical assistance~~ medicaid, as a condition of eligibility, to provide documentation of their income and resources up to five years prior to the ~~time of application~~ date the individual becomes an institutionalized individual if the individual is eligible for medicaid on that date or the date the individual applies for medicaid while an institutionalized individual. Documentation may include, but is not limited to, tax returns, records from financial institutions, and real property records.

(F) The director shall, by rule adopted in accordance with section 111.15 of the Revised Code, establish standards consistent with federal law for allocating income and resources as income and resources of the spouse, children, parents, or stepparents of a recipient of or applicant for ~~medical assistance~~ medicaid. Notwithstanding any provision of state law, including statutes, administrative rules, common law, and court rules, regarding real or personal property or domestic relations, the standards established under this division shall be used to determine eligibility for ~~medical assistance~~ medicaid.

(G) The director may, by rule adopted in accordance with section 111.15 of the Revised Code, exempt individuals who apply for or receive ~~any medical assistance~~ medicaid that may be provided pursuant to division (C) of section 5111.01 of the Revised Code from some or all of the requirements of this section.

Sec. 5111.019. (A) The director of job and family services shall submit to the United States secretary of health and human services an amendment to the state medicaid plan to make an individual who meets all of the following requirements eligible for medicaid for the amount of time provided by division (B) of this section:

(1) The individual is the parent of a child under nineteen years of age and resides with the child;

(2) The individual's family income does not exceed ~~one hundred~~ ninety per cent of the federal poverty guidelines;

(3) The individual is not otherwise eligible for medicaid;

(4) The individual satisfies all relevant requirements established by rules adopted under division (D) of section 5111.01 of the Revised Code.

(B) An individual is eligible to receive medicaid under this section for a period that does not exceed two years beginning on the date on which eligibility is established.

~~(C) If approved by the United States secretary of health and human services and the director of job and family services, the director shall implement the medicaid plan amendment submitted under this section not sooner than July 1, 2000. If a federal waiver is necessary for the United States secretary to approve the amendment, the director of job and family services shall submit a waiver request to the United States secretary not later than ninety days after the effective date of this section.~~

Sec. 5111.0112. ~~The~~ (A) Not later than July 1, 2006, the director of job and family services shall ~~examine instituting~~ institute a copayment program under medicaid. ~~As part of the examination, the director shall determine which groups of medicaid recipients may be subjected to a copayment requirement under~~ The copayment program shall establish a copayment requirement for only dental services, vision services, nonemergency emergency department services, and prescription drugs, other than generic drugs, to the extent permitted by federal statutes and regulations. ~~If, on completion of the examination, the director determines that it is feasible to institute such a copayment program, the director may seek approval from the United States secretary of health and human services to institute the copayment program. If necessary, the director may seek approval by applying for a waiver of federal statutes and regulations. If such approval is obtained, the~~ The director shall adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code governing the copayment program.

(B) The copayment program shall, to the extent permitted by federal law, provide for all of the following with regard to any providers

participating in the medicaid program:

(1) No provider shall refuse to provide a service to a medicaid recipient who is unable to pay a required copayment for the service.

(2) Division (B)(1) of this section shall not be considered to do either of the following with regard to a medicaid recipient who is unable to pay a required copayment:

(a) Relieve the medicaid recipient from the obligation to pay a copayment;

(b) Prohibit the provider from attempting to collect an unpaid copayment.

(3) No provider shall waive a medicaid recipient's obligation to pay the provider a copayment.

(4) No provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent, shall pay any copayment on behalf of a medicaid recipient.

(5) If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid copayment imposed by the copayment program as an outstanding debt and may refuse service to a medicaid recipient who owes the provider an outstanding debt. If the provider intends to refuse service to a medicaid recipient who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services.

Sec. 5111.0114. (A) As used in this section, "dangerous drug" and "manufacturer of dangerous drugs" have the same meaning as in section 4729.01 of the Revised Code.

(B) The director of job and family services may enter into or administer an agreement or cooperative arrangement with other states to create or join a multiple-state prescription drug purchasing program for the purpose of negotiating with manufacturers of dangerous drugs to receive discounts or rebates for dangerous drugs dispensed under the medicaid program.

Sec. ~~5111.023~~ 5111.0115. (A) The department of job and family services may provide medical assistance under ~~Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, in addition to such assistance provided under section 5111.01 of the Revised Code~~ the medicaid program, as long as federal funds are provided for such assistance, to each former participant of the Ohio works first program established under Chapter 5107. of the Revised Code who meets all of the following requirements:

(1) Is ineligible to participate in Ohio works first solely as a result of

increased income due to employment;

(2) Is not covered by, and does not have access to, medical insurance coverage through the employer with benefits comparable to those provided under this section, as determined in accordance with rules adopted by the director of job and family services under division (B) of this section;

(3) Meets any other requirement established by rule adopted under division (B) of this section.

(B) The director of job and family services shall adopt such rules under Chapter 119. of the Revised Code as are necessary to implement and administer the medical assistance program under this section.

(C) A person seeking to participate in a program of medical assistance under this section shall apply to the county department of job and family services in the county in which the applicant resides. The application shall be made on a form prescribed by the department of job and family services and furnished by the county department.

(D) If the county department of job and family services determines that a person is eligible to receive medical assistance under this section, the department shall provide assistance, to the same extent and in the same manner as medical assistance is provided to a person eligible for medical assistance pursuant to division (A)(1)(a) of section 5111.01 of the Revised Code, for no longer than twelve months, beginning the month after the date the participant's eligibility for Ohio works first is terminated.

Sec. 5111.02. The director of job and family services shall adopt, and may amend or rescind, rules under Chapter 119. of the Revised Code establishing the amount, duration, and scope of medicaid services. The rules shall be consistent with federal and state law. The rules may be different for different medicaid services. The rules shall establish all of the following:

(A) The conditions under which the medicaid program shall cover and reimburse medicaid services;

(B) The method of reimbursement applicable to each medicaid service;

(C) The amount of reimbursement or, in lieu of amounts, methods by which amounts are to be determined for each medicaid service;

(D) Procedures for enforcing the rules adopted under this section that provide due process protections, including procedures for corrective action plans for, and imposing financial and administrative sanctions on, persons and government entities that violate the rules.

Sec. ~~5111.02~~ 5111.021. ~~(A)~~ Under the ~~medical assistance~~ medicaid program:

~~(1)~~(A) Except as otherwise permitted by federal statute or regulation and at the department's discretion, reimbursement by the department of job

and family services to a medical provider for any medical service rendered under the program shall not exceed the authorized reimbursement level for the same service under the medicare program established under Title XVIII of the "Social Security Act," ~~49~~ 79 Stat. ~~620~~ 286 (~~1935~~ 1965), 42 U.S.C.~~A. 301~~ 1395, as amended.

~~(2)~~(B) Reimbursement for freestanding medical laboratory charges shall not exceed the customary and usual fee for laboratory profiles.

~~(3)~~(C) The department may deduct from payments for services rendered by a medicaid provider under the ~~medical assistance~~ medicaid program any amounts the provider owes the state as the result of incorrect ~~medical assistance~~ medicaid payments the department has made to the provider.

~~(4)~~(D) The department may conduct final fiscal audits in accordance with the applicable requirements set forth in federal laws and regulations and determine any amounts the provider may owe the state. When conducting final fiscal audits, the department shall consider generally accepted auditing standards, which include the use of statistical sampling.

~~(5)~~(E) The number of days of inpatient hospital care for which reimbursement is made on behalf of a medicaid recipient ~~of medical assistance~~ to a hospital that is not paid under a diagnostic-related-group prospective payment system shall not exceed thirty days during a period beginning on the day of the recipient's admission to the hospital and ending sixty days after the termination of that hospital stay, except that the department may make exceptions to this limitation. The limitation does not apply to children participating in the program for medically handicapped children established under section 3701.023 of the Revised Code.

~~(B) The director of job and family services may adopt, amend, or rescind rules under Chapter 119. of the Revised Code establishing the amount, duration, and scope of medical services to be included in the medical assistance program. Such rules shall establish the conditions under which services are covered and reimbursed, the method of reimbursement applicable to each covered service, and the amount of reimbursement or, in lieu of such amounts, methods by which such amounts are to be determined for each covered service. Any rules that pertain to nursing facilities or intermediate care facilities for the mentally retarded shall be consistent with sections 5111.20 to 5111.33 of the Revised Code.~~

~~(C)~~(F) The division of any reimbursement between a collaborating physician or podiatrist and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner for services performed by the nurse shall be determined and agreed on by the nurse and collaborating physician or podiatrist. In no case shall reimbursement exceed the payment

that the physician or podiatrist would have received had the physician or podiatrist provided the entire service.

Sec. ~~5111.021~~ 5111.022. Under the ~~medical assistance~~ medicaid program, any amount determined to be owed the state by a final fiscal audit conducted pursuant to division ~~(A)(4)~~(D) of section ~~5111.02~~ 5111.021 of the Revised Code, upon the issuance of an adjudication order pursuant to Chapter 119. of the Revised Code that contains a finding that there is a preponderance of the evidence that the provider will liquidate assets or file bankruptcy in order to prevent payment of the amount determined to be owed the state, becomes a lien upon the real and personal property of the provider. Upon failure of the provider to pay the amount to the state, the director of job and family services shall file notice of the lien, for which there shall be no charge, in the office of the county recorder of the county in which it is ascertained that the provider owns real or personal property. The director shall notify the provider by mail of the lien, but absence of proof that the notice was sent does not affect the validity of the lien. The lien is not valid as against the claim of any mortgagee, pledgee, purchaser, judgment creditor, or other lienholder of record at the time the notice is filed.

If the provider acquires real or personal property after notice of the lien is filed, the lien shall not be valid as against the claim of any mortgagee, pledgee, subsequent bona fide purchaser for value, judgment creditor, or other lienholder of record to such after-acquired property unless the notice of lien is refiled after the property is acquired by the provider and before the competing lien attaches to the after-acquired property or before the conveyance to the subsequent bona fide purchaser for value.

When the amount has been paid, the provider may record with the recorder notice of the payment. For recording such notice of payment, the recorder shall charge and receive from the provider a base fee of one dollar for services and a housing trust fund fee of one dollar pursuant to section 317.36 of the Revised Code.

In the event of a distribution of a provider's assets pursuant to an order of any court under the law of this state including any receivership, assignment for benefit of creditors, adjudicated insolvency, or similar proceedings, amounts then or thereafter due the state under this chapter have the same priority as provided by law for the payment of taxes due the state and shall be paid out of the receivership trust fund or other such trust fund in the same manner as provided for claims for unpaid taxes due the state.

If the attorney general finds after investigation that any amount due the state under this chapter is uncollectable, in whole or in part, the attorney

general shall recommend to the director the cancellation of all or part of the claim. The director may thereupon effect the cancellation.

Sec. ~~5111.022~~ 5111.023. (A) As used in this section:

(1) "Community mental health facility" means a community mental health facility that has a quality assurance program accredited by the joint commission on accreditation of healthcare organizations or is certified by the department of mental health or department of job and family services.

(2) "Mental health professional" means a person qualified to work with mentally ill persons under the standards established by the director of mental health pursuant to section 5119.611 of the Revised Code.

(B) The state medicaid plan shall include provision of the following mental health services when provided by community mental health facilities:

(1) Outpatient mental health services, including, but not limited to, preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, monitored, and reviewed;

(2) Partial-hospitalization mental health services of three to fourteen hours per service day, rendered by persons directly supervised by a mental health professional;

(3) Unscheduled, emergency mental health services of a kind ordinarily provided to persons in crisis when rendered by persons supervised by a mental health professional;

(4) Subject to receipt of federal approval, assertive community treatment and intensive home-based mental health services.

(C) The comprehensive annual plan shall certify the availability of sufficient unencumbered community mental health state subsidy and local funds to match federal medicaid reimbursement funds earned by community mental health facilities.

(D) The department of job and family services shall enter into a separate contract with the department of mental health under section 5111.91 of the Revised Code with regard to the component of the medicaid program provided for by this section.

(E) Not later than July 21, ~~2004~~ 2006, the department of job and family services shall request federal approval to provide assertive community treatment and intensive home-based mental health services under medicaid pursuant to this section.

(F) On receipt of federal approval sought under division (E) of this section, the director of job and family services shall adopt rules in

accordance with Chapter 119. of the Revised Code for assertive community treatment and intensive home-based mental health services provided under medicaid pursuant to this section. The director shall consult with the department of mental health in adopting the rules.

Sec. 5111.025. (A) In rules adopted under section 5111.02 of the Revised Code, the director of job and family services shall modify the manner or establish a new manner in which the following are paid under medicaid:

(1) Community mental health facilities for providing mental health services included in the state medicaid plan pursuant to section ~~5111.022~~ 5111.023 of the Revised Code;

(2) Providers of alcohol and drug addiction services for providing alcohol and drug addiction services included in the medicaid program pursuant to rules adopted under section 5111.02 of the Revised Code.

(B) The director's authority to modify the manner, or to establish a new manner, for medicaid to pay for the services specified in division (A) of this section is not limited by any rules adopted under section 5111.02 or 5119.61 of the Revised Code that are in effect on ~~the effective date of this section~~ June 26, 2003, and govern the way medicaid pays for those services. This is the case regardless of what state agency adopted the rules.

Sec. 5111.027. If the medicaid program provides prescription drug services to medicaid recipients, the program shall not provide reimbursement for prescription drugs for treatment of erectile dysfunction.

Sec. 5111.042. The departments of mental retardation and developmental disabilities and job and family services may approve, reduce, deny, or terminate a service included in the individualized service plan developed for a medicaid recipient with mental retardation or other developmental disability who is eligible for medicaid case management services. ~~The departments shall consider the recommendations a county board of mental retardation and developmental disabilities makes under division (B)(1) of section 5126.055 of the Revised Code.~~ If either department approves, reduces, denies, or terminates a service, that department shall timely notify the medicaid recipient that the recipient may request a hearing under section 5101.35 of the Revised Code.

Sec. 5111.06. (A)(1) As used in this section and in sections 5111.061 and 5111.062 of the Revised Code:

(a) "Provider" means any person, institution, or entity that furnishes medicaid services under a provider agreement with the department of job and family services pursuant to Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

(b) "Party" has the same meaning as in division (G) of section 119.01 of the Revised Code.

(c) "Adjudication" has the same meaning as in division (D) of section 119.01 of the Revised Code.

(2) This section does not apply to any action taken by the department of job and family services under sections 5111.35 to 5111.62 of the Revised Code.

(B) Except as provided in division (D) of this section and section 5111.914 of the Revised Code, the department shall do either of the following by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code:

(1) Enter into or refuse to enter into a provider agreement with a provider, or suspend, terminate, renew, or refuse to renew an existing provider agreement with a provider;

(2) Take any action based upon a final fiscal audit of a provider.

(C) Any party who is adversely affected by the issuance of an adjudication order under division (B) of this section may appeal to the court of common pleas of Franklin county in accordance with section 119.12 of the Revised Code.

(D) The department is not required to comply with division (B)(1) of this section whenever any of the following occur:

(1) The terms of a provider agreement require the provider to have a license, permit, or certificate issued by an official, board, commission, department, division, bureau, or other agency of state government other than the department of job and family services, and the license, permit, or certificate has been denied or revoked.

(2) The provider agreement is denied, terminated, or not renewed pursuant to division (C) or (E) of section 5111.03 of the Revised Code;

(3) The provider agreement is denied, terminated, or not renewed due to the provider's termination, suspension, or exclusion from the medicare program established under Title XVIII of the "Social Security Act," and the termination, suspension, or exclusion is binding on the provider's participation in the medicaid program;

(4) The provider agreement is denied, terminated, or not renewed due to the provider's pleading guilty to or being convicted of a criminal activity materially related to either the medicare or medicaid program;

(5) The provider agreement is denied, terminated, or suspended as a result of action by the United States department of health and human services and that action is binding on the provider's participation in the medicaid program;

(6) The provider agreement is terminated or not renewed because the provider has not billed or otherwise submitted a medicaid claim to the department for two years or longer, and the department has determined that the provider has moved from the address on record with the department without leaving an active forwarding address with the department.

In the case of a provider described in division (D)(6) of this section, the department may terminate or not renew the provider agreement by sending a notice explaining the department's proposed action to the address on record with the department. The notice may be sent by regular mail.

(E) The department may withhold payments for services rendered by a medicaid provider under the medical assistance program during the pendency of proceedings initiated under division (B)(1) of this section. If the proceedings are initiated under division (B)(2) of this section, the department may withhold payments only to the extent that they equal amounts determined in a final fiscal audit as being due the state. This division does not apply if the department fails to comply with section 119.07 of the Revised Code, requests a continuance of the hearing, or does not issue a decision within thirty days after the hearing is completed. This division does not apply to nursing facilities and intermediate care facilities for the mentally retarded as defined in section 5111.20 of the Revised Code.

Sec. 5111.061. (A) The department of job and family services may recover a medicaid payment or portion of a payment made to a provider to which the provider is not entitled. The recovery may occur at any time during the five-year period immediately following the end of the state fiscal year in which the overpayment was made.

(B) Among the overpayments that may be recovered under this section are the following:

(1) Payment for a service, or a day of service, not rendered;

(2) Payment for a day of service at a full per diem rate that should have been paid at a percentage of the full per diem rate;

(3) Payment for a service, or day of service, that was paid by, or partially paid by, a third-party, as defined in section 5101.571 of the Revised Code, and the third-party's payment or partial payment was not offset against the amount paid by the medicaid program to reduce or eliminate the amount that was paid by the medicaid program;

(4) Payment when a medicaid recipient's responsibility for payment was understated and resulted in an overpayment to the provider.

(C) During the period specified in division (A) of this section, the department may recover an overpayment under this section prior to or after any of the following:

(1) Adjudication of a final fiscal audit that section 5111.06 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;

(2) Adjudication of a finding under any other provision of this chapter or the rules adopted under it;

(3) Expiration of the time to issue a final fiscal audit that section 5111.06 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code;

(4) Expiration of the time to issue a finding under any other provision of this chapter or the rules adopted under it.

(D)(1) Subject to division (D)(2) of this section, the recovery of an overpayment under this section does not preclude the department from subsequently doing the following:

(a) Issuing a final fiscal audit in accordance with Chapter 119. of the Revised Code, as required under section 5111.06 of the Revised Code;

(b) Issuing a finding under any other provision of this chapter or the rules adopted under it.

(2) A final fiscal audit or finding issued subsequent to the recovery of an overpayment under this section shall be reduced by the amount of the prior recovery, as appropriate.

(E) Nothing in this section limits the department's authority to recover overpayments pursuant to any other provision of the Revised Code.

Sec. 5111.062. In any action taken by the department of job and family services under section 5111.06 or 5111.061 of the Revised Code or any other provision of this chapter that requires the department to give notice of an opportunity for a hearing in accordance with Chapter 119. of the Revised Code, if the department gives notice of the opportunity for a hearing but the provider or other entity subject to the notice does not request a hearing or timely request a hearing in accordance with section 119.07 of the Revised Code, the department is not required to hold a hearing. The director of job and family service may proceed by issuing a final adjudication order in accordance with Chapter 119. of the Revised Code.

Sec. 5111.082. The director of job and family services, in rules adopted under section 5111.02 of the Revised Code, may establish and implement a supplemental drug rebate program under which drug manufacturers may be required to provide the department of job and family services a supplemental rebate as a condition of having the drug manufacturers' drug products covered by the medicaid program without prior approval. The department may receive a supplemental rebate negotiated under the program for a drug dispensed to a medicaid recipient pursuant to a prescription or a

drug purchased by a medicaid provider for administration to a medicaid recipient in the provider's primary place of business. If necessary, the director may apply to the United States secretary of health and human services for a waiver of federal statutes and regulations to establish the supplemental drug rebate program.

If the director establishes a supplemental drug rebate program, the director shall consult with drug manufacturers regarding the establishment and implementation of the program.

~~If the director establishes a supplemental drug rebate program, the director shall exempt from the program all of a drug manufacturer's drug products that have been approved by the United States food and drug administration for the treatment of either of the following:~~

~~(A) Mental illness, as defined in section 5122.01 of the Revised Code, including schizophrenia, major depressive disorder, and bipolar disorder;~~

~~(B) HIV or AIDS, both as defined in section 3701.24 of the Revised Code.~~

Sec. 5111.083. (A) As used in this section:

(1) "State maximum allowable cost" means the per unit amount the department of job and family services reimburses a terminal distributor of dangerous drugs for a prescription drug included in the state maximum allowable cost program established under division (B) of this section. "State maximum allowable cost" excludes dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.

(2) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.

(B) The director of job and family services shall establish a state maximum allowable cost program for purposes of managing reimbursement to terminal distributors of dangerous drugs for prescription drugs identified by the director pursuant to this division. The director shall do all of the following with respect to the program:

(1) Identify and create a list of prescription drugs to be included in the program.

(2) Update the list of prescription drugs described in division (B)(1) of this section on a weekly basis.

(3) Review the state maximum allowable cost for each drug included on the list described in division (B)(1) of this section on a weekly basis.

(C) The director may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 5111.084. (A) As used in this section, "licensed health professional authorized to prescribe drugs" has the same meaning as in section 4729.01

of the Revised Code.

(B) The director of job and family services may establish an e-prescribing system for the medicaid program under which a medicaid provider who is a licensed health professional authorized to prescribe drugs shall use an electronic system to prescribe a drug for a medicaid recipient when required to do so by division (C) of this section. The e-prescribing system shall eliminate the need for such medicaid providers to make prescriptions for medicaid recipients by handwriting or telephone. The e-prescribing system also shall provide such medicaid providers with an up-to-date, clinically relevant drug information database and a system of electronically monitoring medicaid recipients' medical history, drug regimen compliance, and fraud and abuse.

(C) If the director establishes an e-prescribing system under division (B) of this section, the director shall do all of the following:

(1) Require that a medicaid provider who is a licensed health professional authorized to prescribe drugs use the e-prescribing system during a fiscal year if the medicaid provider was one of the ten medicaid providers who, during the calendar year that precedes that fiscal year, issued the most prescriptions for medicaid recipients receiving hospital services;

(2) Before the beginning of each fiscal year, determine the ten medicaid providers that issued the most prescriptions for medicaid recipients receiving hospital services during the calendar year that precedes the upcoming fiscal year and notify those medicaid providers that they must use the e-prescribing system for the upcoming fiscal year;

(3) Seek the most federal financial participation available for the development and implementation of the e-prescribing system.

Sec. ~~5111.81~~ 5111.085. There is hereby established the pharmacy and therapeutics committee of the department of job and family services. The committee shall consist of ~~eight~~ nine members and shall be appointed by the director of job and family services. The membership of the committee shall include: ~~two~~ three pharmacists licensed under Chapter 4729. of the Revised Code; two doctors of medicine and two doctors of osteopathy licensed under Chapter 4731. of the Revised Code; a registered nurse licensed under Chapter 4723. of the Revised Code; and a pharmacologist who has a doctoral degree. The committee shall elect one of its members as chairperson.

Sec. 5111.10. The director of job and family services may conduct reviews of the medicaid program. The reviews may include physical inspections of records and sites where medicaid-funded services are provided and interviews of providers and recipients of the services. If the

director determines pursuant to a review that a person or government entity has violated a rule governing the medicaid program, the director may establish a corrective action plan for the violator and impose fiscal, administrative, or both types of sanctions on the violator in accordance with rules governing the medicaid program. Such action to be taken against a responsible entity, as defined in section 5101.24 of the Revised Code, shall be taken in accordance with that section.

Sec. 5111.11. (A) As used in this section~~, "estate" means all~~ and section 5111.111 of the Revised Code:

(1) "Estate" includes both of the following:

(a) All real and personal property and other assets to be administered under Title XXI of the Revised Code and property that would be administered under that title if not for section 2113.03 or 2113.031 of the Revised Code;

(b) Any other real and personal property and other assets in which an individual had any legal title or interest at the time of death (to the extent of the interest), including assets conveyed to a survivor, heir, or assign of the individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(2) "Institution" means a nursing facility, intermediate care facility for the mentally retarded, or a medical institution.

(3) "Intermediate care facility for the mentally retarded" and "nursing facility" have the same meanings as in section 5111.20 of the Revised Code.

(4) "Permanently institutionalized individual" means an individual to whom all of the following apply:

(a) Is an inpatient in an institution;

(b) Is required, as a condition of the medicaid program paying for the individual's services in the institution, to spend for costs of medical or nursing care all of the individual's income except for an amount for personal needs specified by the department of job and family services;

(c) Cannot reasonably be expected to be discharged from the institution and return home as determined by the department of job and family services.

(5) "Time of death" shall not be construed to mean a time after which a legal title or interest in real or personal property or other asset may pass by survivorship or other operation of law due to the death of the decedent or terminate by reason of the decedent's death.

(B) ~~For the purpose of recovering the cost of services correctly paid under the medical assistance program to a recipient age fifty-five or older, the~~ To the extent permitted by federal law, the department of job and family services shall institute an estate recovery program ~~against the property and~~

~~estates of medical assistance recipients to recover medical assistance correctly paid on their behalf to the extent that federal law and regulations permit the implementation of a program of that nature. The department shall seek to recover medical assistance correctly paid only after the recipient and the recipient's surviving spouse, if any, have died and only at a time when the recipient has no surviving child who is under age twenty-one or blind or permanently and totally disabled.~~

~~The department may enter into a contract with any person under which the person administers the estate recovery program on behalf of the department or performs any of the functions required to carry out the program. The contract may provide for the person to be compensated from the property recovered from the estates of medical assistance recipients or may provide for another manner of compensation agreed to by the person and the department. Regardless of whether it is administered by the department or a person under contract with the department, the program shall be administered in accordance with applicable requirements of federal law and regulations and state law and rules.~~

~~(C)~~ under which the department shall, except as provided in divisions (C) and (D) of this section, do both of the following:

(1) For the costs of medicaid services the medicaid program correctly paid or will pay on behalf of a permanently institutionalized individual of any age, seek adjustment or recovery from the individual's estate or on the sale of property of the individual or spouse that is subject to a lien imposed under section 5111.111 of the Revised Code;

(2) For the costs of medicaid services the medicaid program correctly paid or will pay on behalf of an individual fifty-five years of age or older who is not a permanently institutionalized individual, seek adjustment or recovery from the individual's estate.

(C)(1) No adjustment or recovery may be made under division (B)(1) of this section from a permanently institutionalized individual's estate or on the sale of property of a permanently institutionalized individual that is subject to a lien imposed under section 5111.111 of the Revised Code or under division (B)(2) of this section from an individual's estate while either of the following are alive:

(a) The spouse of the permanently institutionalized individual or individual;

(b) The son or daughter of a permanently institutionalized individual or individual if the son or daughter is under age twenty-one or, under 42 U.S.C. 1382c, is considered blind or disabled.

(2) No adjustment or recovery may be made under division (B)(1) of

this section from a permanently institutionalized individual's home that is subject to a lien imposed under section 5111.111 of the Revised Code while either of the following lawfully reside in the home:

(a) The permanently institutionalized individual's sibling who resided in the home for at least one year immediately before the date of the permanently institutionalized individual's admission to the institution and on a continuous basis since that time;

(b) The permanently institutionalized individual's son or daughter who provided care to the permanently institutionalized individual that delayed the permanently institutionalized individual's institutionalization and resided in the home for at least two years immediately before the date of the permanently institutionalized individual's admission to the institution and on a continuous basis since that time.

(D) The department ~~may~~ shall waive seeking an adjustment or recovery ~~of medical assistance correctly paid~~ otherwise required by this section if the director of job and family services determines that adjustment or recovery would work an undue hardship. ~~The~~ The department may limit the duration of the waiver to the period during which the undue hardship exists.

The director, in accordance with Chapter 119. of the Revised Code, shall adopt rules ~~establishing~~ regarding the estate recovery program, including rules that establish procedures and criteria for waiver of adjustment or recovery due to an undue hardship~~, which~~. These rules shall meet the standards specified by the United States secretary of health and human services under 42 U.S.C. 1396p(b)(3), as amended.

~~(D) Any action that may be taken by the department under section 5111.111 of the Revised Code may be taken by a person administering the program, or performing actions specified in that section, pursuant to a contract with the department.~~

(E) For the purpose of determining whether an individual meets the definition of "permanently institutionalized individual" established for this section, a rebuttable presumption exists that the individual cannot reasonably be expected to be discharged from an institution and return home if either of the following is the case:

(1) The individual declares that he or she does not intend to return home.

(2) The individual has been an inpatient in an institution for at least six months.

Sec. 5111.111. ~~As used in this section, "home and community-based services" means services provided pursuant to a waiver under section 1915 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396n, as~~

~~amended.~~

~~The~~ (A) Except as provided in division (B) of this section and section 5111.12 of the Revised Code, no lien may be imposed against the property of an individual before the individual's death on account of medicaid services correctly paid or to be paid on the individual's behalf.

(B) Except as provided in division (C) of this section, the department of job and family services may ~~place~~ impose a lien against the real property of a ~~medical assistance~~ medicaid recipient ~~or~~ who is a permanently institutionalized individual and against the real property of the recipient's spouse, ~~other than a recipient or spouse of a recipient of home and community-based services, that the department may recover as part of the program instituted under section 5111.11 of the Revised Code~~ including any real property that is jointly held by the recipient and spouse. ~~When medical assistance is paid on behalf of any person in circumstances under which federal law and regulations and this section permit the imposition of a lien, the~~ The lien may be imposed on account of medicaid paid or to be paid on the recipient's behalf.

(C) No lien may be imposed under division (B) of this section against the home of a medicaid recipient if any of the following lawfully resides in the home:

(1) The recipient's spouse;

(2) The recipient's son or daughter who is under twenty-one years of age or, under 42 U.S.C. 1382c, considered to be blind or disabled;

(3) The recipient's sibling who has an equity interest in the home and resided in the home for at least one year immediately before the date of the recipient's admission to the institution.

(D) The director of job and family services or a person designated by the director ~~may~~ shall sign a certificate to ~~the effect~~ effectuate a lien required to be imposed under this section. The county department of job and family services shall file for recording and indexing the certificate, or a certified copy, in the real estate mortgage records in the office of the county recorder in every county in which real property of the recipient or spouse is situated. From the time of filing the certificate in the office of the county recorder, the lien attaches to all real property of the recipient or spouse described ~~therein~~ in the certificate for all amounts ~~of aid which are paid or which thereafter are paid,~~ for which adjustment or recovery may be made under section 5111.11 of the Revised Code and, except as provided in division (E) of this section, shall remain a lien until satisfied.

Upon filing the certificate in the office of the recorder, all persons are charged with notice of the lien and the rights of the department of job and

family services thereunder.

The county recorder shall keep a record of every certificate filed showing its date, the time of filing, the name and residence of the recipient or spouse, and any release, waivers, or satisfaction of the lien.

The priority of the lien shall be established in accordance with state and federal law.

The department may waive the priority of its lien to provide for the costs of the last illness as determined by the department, administration, attorney fees, administrator fees, a sum for the payment of the costs of burial, which shall be computed by deducting from five hundred dollars whatever amount is available for the same purpose from all other sources, and a similar sum for the spouse of the decedent.

(E) A lien imposed with respect to a medicaid recipient under this section shall dissolve on the recipient's discharge from the institution and return home.

Sec. 5111.112. The department of job and family services shall certify amounts due under the estate recovery program instituted under section 5111.11 of the Revised Code to the attorney general pursuant to section 131.02 of the Revised Code. The attorney general may enter into a contract with any person or government entity to collect the amounts due on behalf of the attorney general.

The attorney general, in entering into a contract under this section, shall comply with all of the requirements that must be met for the state to receive federal financial participation for the costs incurred in entering into the contract and carrying out actions under the contract. The contract may provide for the person or government entity with which the attorney general contracts to be compensated from the property recovered under the estate recovery program or may provide for another manner of compensation agreed to by the parties to the contract.

Regardless of whether the attorney general collects the amounts due under the estate recovery program or contracts with a person or government entity to collect the amounts due on behalf of the attorney general, the amounts due shall be collected in accordance with applicable requirements of federal statutes and regulations and state statutes and rules.

Sec. ~~5111.112~~ 5111.113. (A) As used in this section:

(1) "Adult care facility" has the same meaning as in section 3722.01 of the Revised Code.

(2) "Commissioner" means a person appointed by a probate court under division (B) of section 2113.03 of the Revised Code to act as a commissioner.

(3) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(4) "Personal needs allowance account" means an account or petty cash fund that holds the money of a resident of an adult care facility or home and that the facility or home manages for the resident.

(B) Except as provided in divisions (C) and (D) of this section, the owner or operator of an adult care facility or home shall transfer to the department of job and family services the money in the personal needs allowance account of a resident of the facility or home who was a recipient of the medical assistance program no earlier than sixty days but not later than ninety days after the resident dies. The adult care facility or home shall transfer the money even though the owner or operator of the facility or home has not been issued letters testamentary or letters of administration concerning the resident's estate.

(C) If funeral or burial expenses for a resident of an adult care facility or home who has died have not been paid and the only resource the resident had that could be used to pay for the expenses is the money in the resident's personal needs allowance account, or all other resources of the resident are inadequate to pay the full cost of the expenses, the money in the resident's personal needs allowance account shall be used to pay for the expenses rather than being transferred to the department of job and family services pursuant to division (B) of this section.

(D) If, not later than sixty days after a resident of an adult care facility or home dies, letters testamentary or letters of administration are issued, or an application for release from administration is filed under section 2113.03 of the Revised Code, concerning the resident's estate, the owner or operator of the facility or home shall transfer the money in the resident's personal needs allowance account to the administrator, executor, commissioner, or person who filed the application for release from administration.

(E) The transfer or use of money in a resident's personal needs allowance account in accordance with division (B), (C), or (D) of this section discharges and releases the adult care facility or home, and the owner or operator of the facility or home, from any claim for the money from any source.

(F) If, sixty-one or more days after a resident of an adult care facility or home dies, letters testamentary or letters of administration are issued, or an application for release from administration under section 2113.03 of the Revised Code is filed, concerning the resident's estate, the department of job and family services shall transfer the funds to the administrator, executor, commissioner, or person who filed the application, unless the department is

entitled to recover the money under the estate recovery program instituted under section 5111.11 of the Revised Code.

Sec. ~~5111.113~~ 5111.114. As used in this section, "nursing facility" and "intermediate care facility for the ~~mental~~ mentally retarded" have the same meanings as in section 5111.20 of the Revised Code.

In determining the amount of income that a recipient of medical assistance must apply monthly toward payment of the cost of care in a nursing facility or intermediate care facility for the mentally retarded, the county department of job and family services shall deduct from the recipient's monthly income a monthly personal needs allowance in accordance with section 1902 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396a, as amended.

For a resident of a nursing facility, the monthly personal needs allowance shall be not less than forty dollars for an individual resident and not less than eighty dollars for a married couple if both spouses are residents of a nursing facility.

For a resident of an intermediate care facility for the mentally retarded, the monthly personal needs allowance shall be forty dollars unless the resident has earned income, in which case the monthly personal needs allowance shall be determined by the state department of job and family services but shall not exceed one hundred five dollars.

Sec. 5111.16. (A) As part of the medicaid program, the department of job and family services shall establish a care management system. The department shall submit, if necessary, applications to the United States department of health and human services for waivers of federal medicaid requirements that would otherwise be violated in the implementation of the system.

(B) The department shall implement the care management system in some or all counties and shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, all of the following apply:

(1) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for indivduals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). The department shall designate the participants not later than January 1, 2006. Beginning not later than December 31, 2006, the department shall ensure that all

participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

(2) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division (A)(2) of section 5111.01 of the Revised Code, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for the individuals specified in divisions (B)(2)(a) to (e) of this section. Beginning not later than December 31, 2006, the department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

In designating participants who receive medicaid on the basis of being aged, blind, or disabled, the department shall not include any of the following:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who are institutionalized;

(c) Individuals who become eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements;

(d) Individuals who are dually eligible under the medicaid program and the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended;

(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component, as defined in section 5111.85 of the Revised Code.

(3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug adiction, and mental health services or a state agency other than the department of job and family services, but the recipients of those services may otherwise be designated for participation in the system.

~~(B) Under the care management system~~ (C) Subject to division (B) of this section, the department may do both of the following under the care management system:

(1) Require or permit participants in the system to obtain health care services from providers designated by the department;

(2) ~~require~~ Require or permit participants in the system to obtain health care services through managed care organizations under contract with the department pursuant to section 5111.17 of the Revised Code.

~~(C)~~(D)(1) The department shall prepare an annual report on the care management system. The report shall address the department's ability to implement the system, including all of the following components:

(a) The required designation of participants included in the category identified by the department as covered families and children;

(b) The required designation of participants included in the aged, blind, or disabled category of medicaid recipients;

(c) The conduct of the pilot program for chronically ill children established under section 5111.163 of the Revised Code;

(d) The use of any programs for enhanced care management.

(2) The department shall submit each annual report to the general assembly. The first report shall be submitted not later than October 1, 2007.

(E) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 5111.161. (A) There is hereby created the medicaid care management working group, consisting of the following members:

(1) Three individuals representing medicaid health insuring corporations, as defined in section 5111.176 of the Revised Code, one appointed by the president of the senate, one appointed by the speaker of the house of representatives, and one appointed by the governor;

(2) One individual representing programs that provide enhanced care management services, appointed by the governor;

(3) Four individuals representing health care professional and trade associations, appointed as follows:

(a) One representative of the American academy of pediatrics, appointed by the president of the senate;

(b) One representative of the American academy of family physicians, appointed by the speaker of the house of representatives;

(c) One representative of the Ohio state medical association, appointed by the president of the senate;

(d) One representative of the Ohio hospital association, appointed by the speaker of the house of representatives.

(4) One individual representing behavioral health professional and trade associations, appointed by the speaker of the house of representatives;

(5) Two individuals representing consumer advocates, one appointed by the president of the senate and one appointed by the speaker of the house of representatives;

(6) One individual representing county departments of job and family services, appointed by the president of the senate;

(7) Three individuals representing the business community, one appointed by the president of the senate, one appointed by the speaker of the house of representatives, and one appointed by the governor;

(8) The director of job and family services or the director's designee;

(9) The director of health or the director's designee;

(10) The director of aging or the director's designee.

(B) The members of the working group shall serve at the pleasure of their appointing authorities. Vacancies shall be filled in the manner provided for original appointments.

(C) The working group shall develop guidelines that the department of job and family services may consider when entering into contracts under section 5111.17 of the Revised Code with managed care organizations for purposes of the care management system established under section 5111.16 of the Revised Code. The working group shall consult regularly with the departments of insurance, alcohol and drug addiction services, mental health, and mental retardation and developmental disabilities and the rehabilitation services commission.

In developing the guidelines, the working group shall do all of the following:

(1) Examine the best practice standards used in managed care programs and other health care and related systems to maximize patient and provider satisfaction, maintain quality of care, and obtain cost-effectiveness;

(2) Consider the most effective means of facilitating the expansion of the care management system and increasing consistency within the system;

(3) Make recommendations for coordinating the regulatory relationships involved in the medicaid care management system;

(4) Make recommendations for improving the resolution of contracting issues among the providers involved in the care management system;

(5) Make recommendations that the department may consider when developing and implementing the financial incentive program under division (B) of section 5111.17 of the Revised Code to improve and reward positive health outcomes through managed care contracts. In making these recommendations, the working group shall include all of the following:

(a) Standards and procedures by which care management contractors may receive financial incentives for positive health outcomes measured on an individual basis;

(b) Specific measures of positive health outcomes, particularly among individuals with high-risk health conditions;

(c) Criteria for determining what constitutes a completed health outcome;

(d) Methods of funding the program without requiring an increase in appropriations.

(D) The working group shall prepare an annual report on its activities and shall submit the report to the president of the senate, speaker of the house of representatives, and governor. The report shall include any findings and recommendations the working group considers relevant to its duties. The working group shall complete an initial report not later than December 31, 2005. Each year thereafter, the working group shall complete its annual report by the last day of December.

Sec. 5111.162. (A) As used in this section, "medicaid managed care organization" means a managed care organization that has entered into a contract with the department of job and family services pursuant to section 5111.17 of the Revised Code.

(B) Except as provided in division (C) of this section, when a participant in the care management system established under section 5111.16 of the Revised Code is enrolled in a medicaid managed care organization and the organization refers the participant to a hospital that participates in the medicaid program but is not under contract with the organization, the hospital shall provide the service for which the referral was made and shall accept from the organization, as payment in full, the amount derived from the reimbursement rate used by the department to reimburse other hospitals of the same type for providing the same service to a medicaid recipient who is not enrolled in a medicaid managed care organization.

(C) A hospital is not subject to division (B) of this section if all of the following are the case:

(1) The hospital is located in a county in which participants in the care management system are required before January 1, 2006, to be enrolled in a medicaid managed care organization that is a health insuring corporation;

(2) The hospital has entered into a contract before January 1, 2006, with at least one health insuring corporation serving the participants specified in division (C)(1) of this section;

(3) The hospital remains under contract with at least one health insuring corporation serving participants in the care management system who are required to be enrolled in a health insuring corporation.

(D) The director of job and family services shall adopt rules specifying the circumstances under which a medicaid managed care organization is permitted to refer a participant in the care management system to a hospital that is not under contract with the organization. The director may adopt any other rules necessary to implement this section. All rules adopted under this section shall be adopted in accordance with Chapter 119. of the Revised

Code.

Sec. 5111.163. (A) As used in this section, "chronically ill child" means an individual who is not more than twenty-one years of age and meets the conditions specified in division (A)(2) of section 5111.01 of the Revised Code to be eligible for medicaid on the basis of being blind or disabled.

(B) Notwithstanding any conflicting provision of section 5111.16 of the Revised Code, the department of job and family services shall develop a pilot program for the care management of chronically ill children in accordance with this section. The pilot program shall be implemented not later than October 1, 2006, or, if by that date the department has not received any necessary federal approval to implement the program, as soon as practicable after receiving the approval. The department shall operate the program until October 1, 2008, except that the department shall cease operation of the program before that date if either of the following is the case:

(1) The department determines that requiring chronically ill children to participate in the care management system is not a cost-effective means of providing medicaid services.

(2) The combined state and federal cost of the children's care coordination described in division (D) of this section reaches three million dollars.

(C) The department shall ensure that the pilot program is operated in at least three counties selected by the department. In its consideration of the counties to be selected, the department may give priority to Hamilton county and Muskingum county. The department may extend its operation of the program into the areas surrounding the counties in which the program is operated.

(D) The purpose of the pilot program shall be to determine whether occurrences of acute illnesses and hospitalizations among chronically ill children can be prevented or reduced by establishing a medical home for the children where care is administered proactively and in a manner that is accessible, continuous, family-centered, coordinated, and compassionate. In establishing a medical home for a chronically ill child, all of the following apply:

(1) A physician shall serve as the care coordinator for the child. The care coordinator may be engaged in practice as a pediatrician certified in pediatrics by a medical specialty board of the American medical association or American osteopathic association, a pediatric subspecialist, or a provider for the program for medically handicapped children in the department of health. If the physician is in a group practice, any member of the group

practice may serve as the child's care coordinator. The duties of the care coordinator may be performed by a person acting under the supervision of the care coordinator.

(2) The child may receive care from any health care practitioner appropriate to the child's needs, but the care coordinator shall direct and oversee the child's overall care.

(3) The care coordinator shall establish a relationship of mutual responsibility with the child's parents or other persons who are responsible for the child. Under this relationship, the care coordinator shall commit to developing a long-term disease prevention strategy and providing disease management and education services, while the child's parents or other persons who are responsible for the child shall commit to participating fully in implementing the child's care management plan.

(4) The medicaid program shall provide reimbursement for the reasonable and necessary costs of the services associated with care coordination, including, but not limited to, case management, care plan oversight, preventive care, health and behavioral care assessment and intervention, and any service modifier that reflects the provision of prolonged services or additional care.

(E) The department shall conduct an evaluation of the pilot program's effectiveness. As part of the evaluation, the department shall maintain statistics on physician expenditures, hospital expenditures, preventable hospitalizations, and other matters the department considers necessary to conduct the evaluation.

(F) The department shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. The rules shall specify standards and procedures to be used in designating the chronically ill children who are required to participate in the pilot program.

Sec. 5111.17. (A) The department of job and family services may enter into contracts with managed care organizations, including health insuring corporations, under which the organizations are authorized to provide, or arrange for the provision of, health care services to medical assistance recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under section 5111.16 of the Revised Code.

(B) The department shall develop and implement a financial incentive program to improve and reward positive health outcomes through the managed care organization contracts entered into under this section. In developing and implementing the program, the department may take into consideration the recommendations regarding the program made by the

medicaid care management working group created under section 5111.161 of the Revised Code.

(C) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 5111.176. (A) As used in this section:

(1) "Medicaid health insuring corporation" means a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code and has entered into a contract with the department of job and family services pursuant to section 5111.17 of the Revised Code.

(2) "Managed care premium" means any premium payment, capitation payment, or other payment a medicaid health insuring corporation receives for providing, or arranging for the provision of, health care services to its members or enrollees residing in this state.

(B) Except as provided in division (C) of this section, all of the following apply:

(1) Each medicaid health insuring corporation shall pay to the department of job and family services a franchise permit fee for each calendar quarter occurring between January 1, 2006, and June 30, 2007.

(2) The fee to be paid is an amount that is equal to a percentage of the managed care premiums the medicaid health insuring corporation received in the quarter to which the fee applies, excluding the amount of any managed care premiums the corporation returned or refunded to enrollees, members, or premium payers during that quarter.

(3) The percentage to be used in calculating the fee shall be four and one-half per cent, unless the department adopts rules under division (L) of this section decreasing the percentage below four and one-half per cent or increasing the percentage to not more than six per cent.

(C) The department shall reduce the franchise permit fee imposed under this section or terminate its collection of the fee if the department determines either of the following:

(1) That the reduction or termination is required to comply with federal statutes or regulations;

(2) That the fee does not qualify as a state share of medicaid expenditures eligible for federal financial participation.

(D) The franchise permit fee shall be paid on or before the thirtieth day following the end of the calendar quarter to which the fee applies. At the time the fee is submitted, the medicaid health insuring corporation shall file with the department a report on a form prescribed by the department. The corporation shall provide on the form all information required by the

department and shall include with the form any necessary supporting documentation.

(E) The department may audit the records of any medicaid health insuring corporation to determine whether the corporation is in compliance with this section. The department may audit the records that pertain to a particular calendar quarter at any time during the five years following the date the franchise permit fee payment for that quarter was due.

(F)(1) A medicaid health insuring corporation that does not pay the franchise permit fee in full by the date the payment is due is subject to any or all of the following:

(a) A monetary penalty in the amount of five hundred dollars for each day any part of the fee remains unpaid, except that the penalty shall not exceed an amount equal to five per cent of the total fee that was due for the calendar quarter for which the penalty is being imposed;

(b) Withholdings from future managed care premiums pursuant to division (G) of this section;

(c) Termination of the corporation's medicaid provider agreement pursuant to division (H) of this section.

(2) Penalties imposed under division (F)(1)(a) of this section are in addition to and not in lieu of the franchise permit fee.

(G) If a medicaid health insuring corporation fails to pay the full amount of its franchise permit fee when due, or the full amount of a penalty imposed under division (F)(1)(a) of this section, the department may withhold an amount equal to the remaining amount due from any future managed care premiums to be paid to the corporation under the medicaid program. The department may withhold amounts under this division without providing notice to the corporation. The amounts may be withheld until the amount due has been paid.

(H) The department may commence actions to terminate a medicaid health insuring corporation's medicaid provider agreement, and may terminate the agreement subject to division (I) of this section, if the corporation does any of the following:

(1) Fails to pay its franchise permit fee or fails to pay the fee promptly;

(2) Fails to pay a penalty imposed under division (F)(1)(a) of this section or fails to pay the penalty promptly;

(3) Fails to cooperate with an audit conducted under division (E) of this section.

(I) At the request of a medicaid health insuring corporation, the department shall grant the corporation a hearing in accordance with Chapter 119. of the Revised Code, if either of the following is the case:

(1) The department has determined that the corporation owes an additional franchise permit fee or penalty as the result of an audit conducted under division (E) of this section.

(2) The department is proposing to terminate the corporation's medicaid provider agreement and the provisions of section 5111.06 of the Revised Code requiring an adjudication in accordance with Chapter 119. of the Revised Code are applicable.

(J)(1) At the request of a medicaid corporation, the department shall grant the corporation a reconsideration of any issue that arises out of the provisions of this section and is not subject to division (I) of this section. The department's decision at the conclusion of the reconsideration is not subject to appeal under Chapter 119. of the Revised Code or any other provision of the Revised Code.

(2) In conducting a reconsideration, the department shall do at least the following:

(a) Specify the time frames within which a corporation must act in order to exercise its opportunity for a reconsideration;

(b) Permit the corporation to present written arguments or other materials that support the corporation's position.

(K) There is hereby created in the state treasury the managed care assessment fund. Money collected from the franchise permit fees and penalties imposed under this section shall be credited to the fund. The department shall use the money in the fund to pay for medicaid services, the department's administrative costs, and contracts with medicaid health insuring corporations.

(L) The director of job and family services may adopt rules to implement and administer this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5111.177. When contracting under section 5111.17 of the Revised Code with a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code, the department of job and family services shall require the health insuring corporation to provide a grievance process for medicaid recipients in accordance with 42 C.F.R. 438, subpart F.

Sec. 5111.19. The director of job and family services shall adopt rules governing the calculation and payment of graduate medical education costs associated with services rendered to medicaid recipients ~~of the medical assistance program~~ after June 30, 1994. ~~The~~ Subject to section 5111.191 of the Revised Code, the rules shall provide for reimbursement of graduate medical education costs associated with services rendered to ~~medical assistance~~ medicaid recipients, including recipients enrolled in ~~health~~

~~insuring corporations~~ a managed care organization under contract with the department under section 5111.17 of the Revised Code, that the department determines are allowable and reasonable.

If the department requires a ~~health insuring corporation~~ managed care organization to pay a provider for graduate medical education costs associated with the delivery of services to ~~medical assistance~~ medicaid recipients enrolled in the ~~corporation~~ organization, the department shall include in its payment to the ~~corporation~~ organization an amount sufficient for the ~~corporation~~ organization to pay such costs. If the department does not include in its payments to the ~~health insuring corporation~~ managed care organization amounts for graduate medical education costs of providers, all of the following apply:

(A) ~~The~~ Except as provided in section 5111.191 of the Revised Code, the department shall pay the provider for graduate medical education costs associated with the delivery of services to ~~medical assistance~~ medicaid recipients enrolled in the ~~corporation~~ organization;

(B) No provider shall seek reimbursement from the ~~corporation~~ organization for such costs;

(C) The ~~corporation~~ organization is not required to pay providers for such costs.

Sec. 5111.191. (A) Except as provided in division (B) of this section, the department of job and family services may deny payment to a hospital for direct graduate medical education costs associated with the delivery of services to any medicaid recipient if the hospital refuses without good cause to contract with a managed care organization that serves participants in the care management system established under section 5111.16 of the Revised Code who are required to be enrolled in a managed care organization and the managed care organization serves the area in which the hospital is located.

(B) A hospital is not subject to division (A) of this section if all of the following are the case:

(1) The hospital is located in a county in which participants in the care management system are required before January 1, 2006, to be enrolled in a medicaid managed care organization that is a health insuring corporation.

(2) The hospital has entered into a contract before January 1, 2006, with at least one health insuring corporation serving the participants specified in division (B)(1) of this section.

(3) The hospital remains under contract with at least one health insuring corporation serving participants in the care management system who are required to be enrolled in a health insuring corporation.

(C) The director of job and family services shall specify in the rules adopted under section 5111.19 of the Revised Code what constitutes good cause for a hospital to refuse to contract with a managed care organization.

Sec. 5111.20. As used in sections 5111.20 to 5111.34 of the Revised Code:

(A) "Allowable costs" are those costs determined by the department of job and family services to be reasonable and do not include fines paid under sections 5111.35 to 5111.61 and section 5111.99 of the Revised Code.

(B) "Ancillary and support costs" means all reasonable costs incurred by a nursing facility other than direct care costs or capital costs. "Ancillary and support costs" includes, but is not limited to, costs of activities, social services, pharmacy consultants, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, medical equipment, utilities, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services under section 5111.02 of the Revised Code, for personnel listed in this division. "Ancillary and support costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992.

(C) "Capital costs" means costs of ownership and, in the case of an intermediate care facility for the mentally retarded, costs of nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following:

(i) Buildings;

(ii) Building improvements that are not approved as nonextensive renovations under section ~~5111.25 or~~ 5111.251 of the Revised Code;

(iii) ~~Equipment~~ Except as provided in division (B) of this section,

equipment;

(iv) ~~Extensive~~ In the case of an intermediate care facility for the mentally retarded, extensive renovations;

(v) Transportation equipment.

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Except as provided in division ~~(I)~~(K) of this section, lease and rent of land, building, and equipment.

The costs of capital assets of less than five hundred dollars per item may be considered capital costs ~~of ownership~~ in accordance with a provider's practice.

(2) "Costs of nonextensive renovation" means the actual expense incurred by an intermediate care facility for the mentally retarded for depreciation or amortization and interest on renovations that are not extensive renovations.

~~(C)~~(D) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.

~~(D)~~(E) "Case-mix score" means the measure determined under section ~~5111.231~~ 5111.232 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a resident of a nursing facility or intermediate care facility for the mentally retarded.

~~(E)~~(F) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter, regardless of whether they were subsequently licensed as residential facility beds under section 5123.19 of the Revised Code. For a facility originally licensed as a residential facility under section 5123.19 of the Revised Code, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

(1) If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.

(2) If a facility adds nursing home beds or residential facility beds or extensively renovates all or part of the facility after its original date of licensure, it will have a different date of licensure for the additional beds or

extensively renovated portion of the facility, unless the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time.

~~(F)~~(G) "Desk-reviewed" means that costs as reported on a cost report submitted under section 5111.26 of the Revised Code have been subjected to a desk review under division (A) of section 5111.27 of the Revised Code and preliminarily determined to be allowable costs.

~~(G)~~(H) "Direct care costs" means all of the following:

(1)(a) Costs for registered nurses, licensed practical nurses, and nurse aides employed by the facility;

(b) Costs for direct care staff, administrative nursing staff, medical directors, ~~social services staff, activities staff, psychologists and psychology assistants, social workers and counselors,~~ habilitation staff, qualified mental retardation professionals, program directors, respiratory therapists, habilitation supervisors, and except as provided in division (G)(2) of this section, other persons holding degrees qualifying them to provide therapy;

(c) Costs of purchased nursing services;

(d) Costs of quality assurance;

(e) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code, for personnel listed in divisions ~~(G)~~(H)(1)(a), (b), and (d) of this section;

(f) Costs of consulting and management fees related to direct care;

(g) Allocated direct care home office costs.

(2) In addition to the costs specified in division (H)(1) of this section, for nursing facilities only, direct care costs include medical supplies, emergency oxygen, habilitation supplies, and universal precautions supplies.

(3) In addition to the costs specified in division ~~(G)~~(H)(1) of this section, for intermediate care facilities for the mentally retarded only, direct care costs include both of the following:

(a) Costs for physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech therapists, ~~and~~ audiologists, social services staff, activities staff, psychologists and psychology assistants, and social workers and counselors;

(b) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5111.02

of the Revised Code, for personnel listed in division ~~(C)(2)~~(H)(3)(a) of this section.

~~(3)~~(4) Costs of other direct-care resources that are specified as direct care costs in rules adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code.

~~(H)~~(I) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

~~(I)~~(J) "Franchise permit fee" means the fee imposed by sections 3721.50 to 3721.58 of the Revised Code.

(K) "Indirect care costs" means all reasonable costs incurred by an intermediate care facility for the mentally retarded other than direct care costs, other protected costs, or capital costs. "Indirect care costs" includes but is not limited to costs of habilitation supplies, pharmacy consultants, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code, for personnel listed in this division. Notwithstanding division ~~(B)~~(C)(1) of this section, "indirect care costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992.

~~(J)~~(L) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a nursing facility or intermediate care facility for the mentally retarded that is included in the facility's certified capacity under Title XIX ~~of the "Social Security Act," 49 Stat. 610 (1935), 42 U.S.C.A. 301, as amended~~. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.

~~(K)~~(M) "Intermediate care facility for the mentally retarded" means an

intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the ~~medical assistance~~ medicaid program by the director of health in accordance with Title XIX ~~of the "Social Security Act."~~

~~(L)~~(N) "Maintenance and repair expenses" means, except as provided in division ~~(X)~~(BB)(2) of this section, expenditures that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. "Maintenance and repair expenses" includes but is not limited to the cost of ordinary repairs such as painting and wallpapering.

~~(M)~~(O) "Medicaid days" means all days during which a resident who is a Medicaid recipient eligible for nursing facility services occupies a bed in a nursing facility that is included in the nursing facility's certified capacity under Title XIX. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered Medicaid days proportionate to the percentage of the nursing facility's per resident per day rate paid for those days.

(P) "Nursing facility" means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX ~~of the "Social Security Act,"~~ and is not an intermediate care facility for the mentally retarded. "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX ~~of the "Social Security Act,"~~ and is certified as a skilled nursing facility by the director in accordance with Title XVIII ~~of the "Social Security Act."~~

~~(N)~~(Q) "Operator" means the person or government entity responsible for the daily operating and management decisions for a nursing facility or intermediate care facility for the mentally retarded.

(R) "Other protected costs" means costs incurred by an intermediate care facility for the mentally retarded for medical supplies; real estate, franchise, and property taxes; natural gas, fuel oil, water, electricity, sewage, and refuse and hazardous medical waste collection; allocated other protected home office costs; and any additional costs defined as other protected costs in rules adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code.

~~(O)~~(S)(1) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing facility or intermediate care facility for the mentally retarded:

(a) The land on which the facility is located;

(b) The structure in which the facility is located;

(c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure on or in which the facility is located;

(d) Any lease or sublease of the land or structure on or in which the facility is located.

(2) "Owner" does not mean a holder of a debenture or bond related to the nursing facility or intermediate care facility for the mentally retarded and purchased at public issue or a regulated lender that has made a loan related to the facility unless the holder or lender operates the facility directly or through a subsidiary.

~~(P)~~(T) "Patient" includes "resident."

~~(Q)~~(U) Except as provided in divisions ~~(Q)~~(U)(1) and (2) of this section, "per diem" means a nursing facility's or intermediate care facility for the mentally retarded's actual, allowable costs in a given cost center in a cost reporting period, divided by the facility's inpatient days for that cost reporting period.

(1) When calculating indirect care costs for the purpose of establishing rates under section ~~5111.24 or~~ 5111.241 of the Revised Code, "per diem" means ~~a facility's~~ an intermediate care facility for the mentally retarded's actual, allowable indirect care costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been eighty-five per cent.

(2) When calculating capital costs for the purpose of establishing rates under section ~~5111.25 or~~ 5111.251 of the Revised Code, "per diem" means a facility's actual, allowable capital costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

~~(R)~~(V) "Provider" means ~~a person or government entity that operates a nursing facility or intermediate care facility for the mentally retarded under~~ an operator with a provider agreement.

~~(S)~~(W) "Provider agreement" means a contract between the department of job and family services and the operator of a nursing facility or intermediate care facility for the mentally retarded for the provision of nursing facility services or intermediate care facility services for the mentally retarded under the ~~medical assistance~~ medicaid program.

~~(T)~~(X) "Purchased nursing services" means services that are provided in a nursing facility by registered nurses, licensed practical nurses, or nurse

aides who are not employees of the facility.

~~(U)~~(Y) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

~~(V)~~(Z) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider.

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all of the following conditions are met:

(a) The supplier is a separate bona fide organization.

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes.

(c) The types of goods or services are commonly obtained by other nursing facilities or intermediate care facilities for the mentally retarded from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities.

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

~~(W)~~(AA) "Relative of owner" means an individual who is related to an owner of a nursing facility or intermediate care facility for the mentally retarded by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) ~~Step-parent~~ Stepparent, ~~step-child~~ stepchild, ~~step-brother~~ stepbrother, or ~~step-sister~~ stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster caregiver, foster child, foster brother, or foster sister.

~~(X)~~(BB) "Renovation" and "extensive renovation" mean:

(1) Any betterment, improvement, or restoration of ~~a nursing facility or~~ an intermediate care facility for the mentally retarded started before July 1, 1993, that meets the definition of a renovation or extensive renovation established in rules adopted by the director of job and family services in effect on December 22, 1992.

(2) In the case of betterments, improvements, and restorations of ~~nursing facilities and~~ intermediate care facilities for the mentally retarded started on or after July 1, 1993:

(a) "Renovation" means the betterment, improvement, or restoration of ~~a nursing facility or~~ an intermediate care facility for the mentally retarded beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. A renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A renovation may include costs that otherwise would be considered maintenance and repair expenses if they are an integral part of the structural change that makes up the renovation project. "Renovation" does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity.

(b) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years.

For the purposes of division ~~(X)~~(BB)(2) of this section, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for the estimated rate of inflation from January 1, 1993, to the end of the calendar year during which the renovation is completed, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

The department of job and family services may treat a renovation that

costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if the department determines that the renovation is more prudent than construction of new beds.

(CC) "Title XIX" means Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended.

(DD) "Title XVIII" means Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

Sec. 5111.204. (A) As used in this section ~~and in section 5111.205 of the Revised Code~~, "representative" means a person acting on behalf of an applicant for or recipient of ~~medical assistance~~ medicaid. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on behalf of an applicant or recipient.

(B) The department of job and family services may require ~~an~~ each applicant for or recipient of ~~medical assistance~~ medicaid who applies or intends to apply for admission to a nursing facility or resides in a nursing facility to undergo an assessment to determine whether the applicant or recipient needs the level of care provided by a nursing facility. ~~To~~ The assessment may be performed concurrently with a long-term care consultation provided under section 173.42 of the Revised Code.

To the maximum extent possible, the assessment shall be based on information from the resident assessment instrument specified in rules adopted by the director of job and family services under division ~~(A)~~(E) of section ~~5111.231~~ 5111.232 of the Revised Code. The assessment shall also be based on criteria and procedures established in rules adopted under division ~~(H)~~(F) of this section and information provided by the person being assessed or the person's representative. ~~The~~

The department of job and family services, or if the assessment is performed by ~~another~~ an agency ~~designated~~ under contract with the department pursuant to division (G) of this section ~~5101.754 of the Revised Code~~, the agency, shall, not later than the time the ~~assessment~~ level of care determination based on the assessment is required to be ~~performed~~ provided under division (C) of this section, give written notice of its conclusions and the basis for them to the person assessed and, if the department of job and family services or ~~designated entity~~ agency under contract with the department has been informed that the person has a representative, to the representative.

(C) The department of job and family services or ~~designated~~ agency under contract with the department, whichever performs the assessment, shall ~~perform a complete assessment, or, if circumstances provided by rules adopted under division (H) of this section exist, a partial assessment,~~

provide a level of care determination based on the assessment as follows:

(1) In the case of a person applying or intending to apply for admission to a nursing facility while hospitalized, not later than one of the following:

(a) One working day after the person or the person's representative submits ~~an~~ the application ~~for admission to the nursing facility~~ or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

(2) In the case of ~~an emergency as determined in accordance with rules adopted under division (H) of this section, not later than one calendar day after the person or the person's representative submits the application or notifies the department of the person's intention to apply.~~

~~(3) In all other cases~~ a person applying or intending to apply for admission to a nursing facility who is not hospitalized, not later than one of the following:

(a) Five calendar days after the person or the person's representative submits the application or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

(3) In the case of a person who resides in a nursing facility, not later than one of the following:

(a) Five calendar days after the person or the person's representative submits an application for medical assistance and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

(4) In the case of an emergency, as specified in rules adopted under division (F)(4) of this section, within the number of days specified in the rules.

(D) ~~If the department of job and family services or designated agency conducts a partial assessment under division (C) of this section, it shall complete the rest of the assessment not later than one hundred eighty days after the date the person is admitted to the nursing facility unless the department or designated agency determines the person should be exempt from the assessment.~~

~~(E) A person is not required to be assessed under this section if the circumstances specified by rule adopted under division (H) of this section~~

~~exist or the department of job and family services or designated agency determines after a partial assessment that the person should be exempt from the assessment.~~

~~(F)~~ A person assessed under this section or the person's representative may ~~appeal~~ request a state hearing to dispute the conclusions reached by the department of job and family services or ~~designated~~ agency under contract with the department on the basis of the assessment. The ~~appeal~~ request for a state hearing shall be made in accordance with section 5101.35 of the Revised Code. The department of job and family services or ~~designated~~ agency~~, whichever performs the assessment,~~ under contract with the department shall provide to the person or the person's representative and the nursing facility written notice of the person's right to ~~appeal~~ request a state hearing. The notice shall include an explanation of the procedure for ~~filing an appeal~~ requesting a state hearing. If a state hearing is requested, the state shall be represented in the hearing by the department of job and family services or the agency under contract with the department, whichever performed the assessment.

~~(G)~~(E) A nursing facility that admits or retains a person determined pursuant to an assessment required under ~~division (B) or (C) of~~ this section not to need the level of care provided by the nursing facility shall not be reimbursed under the ~~medical assistance~~ medicaid program for the person's care.

~~(H)~~(F) The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code to implement and administer this section. The rules shall include all of the following:

(1) Criteria and procedures to be used in determining whether admission to a nursing facility or continued stay in a nursing facility is appropriate for the person being assessed~~. The criteria shall include consideration of whether the person is in need of any of the following:~~

~~(a) Nursing or rehabilitation services;~~

~~(b) Assistance with two or more of the activities of daily living;~~

~~(c) Continuous supervision to prevent harm to the person as a result of cognitive impairment.~~;

(2) Information the person being assessed or the person's representative must provide to the department or ~~designated~~ agency under contract with the department for purposes of the assessment and providing a level of care determination based on the assessment;

(3) ~~Circumstances under which the department of job and family services or designated agency may perform a partial assessment under division (C) of this section;~~

~~(4)~~ Circumstances under which a person is not required to be assessed;

(4) Circumstances that constitute an emergency for purposes of division (C)(4) of this section and the number of days within which a level of care determination must be provided in the case of an emergency.

(G) Pursuant to section 5111.91 of the Revised Code, the department of job and family services may enter into contracts in the form of interagency agreements with one or more other state agencies to perform the assessments required under this section. The interagency agreements shall specify the responsibilities of each agency in the performance of the assessments.

Sec. 5111.21. (A) ~~Subject to sections 5111.01, 5111.011, 5111.012, 5111.02, and 5111.211 of the Revised Code, the department of job and family services shall pay, as provided in sections 5111.20 to 5111.32 of the Revised Code, the reasonable costs of services provided to an eligible medicaid recipient by an eligible nursing facility or intermediate care facility for the mentally retarded.~~

In order to be eligible for ~~medical assistance~~ medicaid payments, the operator of a nursing facility or intermediate care facility for the mentally retarded shall do all of the following:

(1) Enter into a provider agreement with the department as provided in section 5111.22, 5111.671, or 5111.672 of the Revised Code;

(2) Apply for and maintain a valid license to operate if so required by law;

(3) Comply with all applicable state and federal laws and rules.

(B) ~~A~~ (1) Except as provided in division (B)(2) of this section, the operator of a nursing facility that elects to obtain and maintain eligibility for payments under the medicaid program shall qualify all of the facility's medicaid-certified beds in the medicare program established by Title XVIII ~~of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395~~. The director of job and family services may adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code to establish the time frame in which a nursing facility must comply with this requirement.

(2) The Ohio veteran's home agency is not required to qualify all of the medicaid-certified beds in a nursing facility the agency maintains and operates under section 5907.01 of the Revised Code in the medicare program.

Sec. 5111.22. A provider agreement between the department of job and family services and the provider of a nursing facility or intermediate care facility for the mentally retarded shall contain the following provisions:

(A) The department agrees to make payments to the ~~nursing facility or~~

~~intermediate care facility for the mentally retarded for patients eligible for services under the medical assistance program~~ provider, as provided in sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code, for medicaid-covered services the facility provides to a resident of the facility who is a medicaid recipient. No payment shall be made for the day a medicaid recipient is discharged from the facility.

(B) The provider agrees to:

(1) Maintain eligibility as provided in section 5111.21 of the Revised Code;

(2) Keep records relating to a cost reporting period for the greater of seven years after the cost report is filed or, if the department issues an audit report in accordance with division (B) of section 5111.27 of the Revised Code, six years after all appeal rights relating to the audit report are exhausted;

(3) File reports as required by the department;

(4) Open all records relating to the costs of its services for inspection and audit by the department;

(5) Open its premises for inspection by the department, the department of health, and any other state or local authority having authority to inspect;

(6) Supply to the department such information as it requires concerning the facility's services to ~~patients~~ residents who are or are eligible to be medicaid recipients;

(7) Comply with section 5111.31 of the Revised Code.

The provider agreement may contain other provisions that are consistent with law and considered necessary by the department.

A provider agreement shall be effective for no longer than twelve months, except that if federal statute or regulations authorize a longer term, it may be effective for a longer term so authorized. A provider agreement may be renewed only if the facility is certified by the department of health for participation in the medicaid program.

The department of job and family services, in accordance with rules adopted ~~by the director pursuant to Chapter 119.~~ under section 5111.02 of the Revised Code, may elect not to enter into, not to renew, or to terminate a provider agreement when the department determines that such an agreement would not be in the best interests of ~~the~~ medicaid recipients or of the state.

Sec. 5111.221. The department of job and family services shall make its best efforts each year to calculate rates under sections ~~5111.23~~ 5111.20 to ~~5111.29~~ 5111.33 of the Revised Code in time to use them to make the payments due to ~~nursing facilities and intermediate care facilities for the mentally retarded~~ providers by the fifteenth day of August. If the department

is unable to calculate the rates so that they can be paid by that date, the department shall pay each ~~facility~~ provider the rate calculated for ~~it~~ the provider's nursing facilities and intermediate care facilities for the mentally retarded under those sections at the end of the previous fiscal year. If the department also is unable to calculate the rates to make the payments due by the fifteenth day of September and the fifteenth day of October, the department shall pay the previous fiscal year's rate to make those payments. The department may increase by five per cent the previous fiscal year's rate paid ~~to~~ for any facility pursuant to this section at the request of the ~~facility~~ provider. The department shall use rates calculated for the current fiscal year to make the payments due by the fifteenth day of November.

If the rate paid to a provider for a facility pursuant to this section is lower than the rate calculated for ~~it~~ the facility for the current fiscal year, the department shall pay the ~~facility~~ provider the difference between the two rates for the number of days for which the ~~facility~~ provider was paid for the facility pursuant to this section. If the rate paid ~~to~~ for a facility pursuant to this section is higher than the rate calculated for it for the current fiscal year, the ~~facility~~ provider shall refund to the department the difference between the two rates for the number of days for which the ~~facility~~ provider was paid for the facility pursuant to this section.

Sec. 5111.222. (A) Except as otherwise provided by sections 5111.20 to 5111.33 of the Revised Code and by division (B) of this section, the payments that the department of job and family services shall agree to make to the provider of a nursing facility pursuant to a provider agreement shall equal the sum of all of the following:

(1) The rate for direct care costs determined for the nursing facility under section 5111.231 of the Revised Code;

(2) The rate for ancillary and support costs determined for the nursing facility's ancillary and support cost peer group under section 5111.24 of the Revised Code;

(3) The rate for tax costs determined for the nursing facility under section 5111.242 of the Revised Code;

(4) The rate for franchise permit fees determined for the nursing facility under section 5111.243 of the Revised Code;

(5) The quality incentive payment paid to the nursing facility's quality tier group under section 5111.244 of the Revised Code;

(6) The median rate for capital costs for the nursing facilities in the nursing facility's capital costs peer group as determined under section 5111.25 of the Revised Code.

(B) The department shall adjust the payment otherwise determined

under division (A) of this section as directed by the general assembly through the enactment of law governing medicaid payments to providers of nursing facilities, including any law that does either of the following:

(1) Establishes factors by which the payments are to be adjusted;

(2) Establishes a methodology for phasing in the rates determined for fiscal year 2006 under uncodified law the general assembly enacts to rates determined for subsequent fiscal years under sections 5111.20 to 5111.33 of the Revised Code.

Sec. 5111.223. The operator of a nursing facility or intermediate care facility for the mentally retarded may enter into provider agreements for more than one nursing facility or intermediate care facility for the mentally retarded.

Sec. 5111.23. (A) The department of job and family services shall pay a provider for each of the provider's eligible ~~nursing facility and~~ intermediate care ~~facility~~ facilities for the mentally retarded a per resident per day rate for direct care costs established prospectively for each facility. The department shall establish each facility's rate for direct care costs quarterly.

(B) Each facility's rate for direct care costs shall be based on the facility's cost per case-mix unit, subject to the maximum costs per case-mix unit established under division (B)(2) of this section, from the calendar year preceding the fiscal year in which the rate is paid. To determine the rate, the department shall do all of the following:

(1) Determine each facility's cost per case-mix unit for the calendar year preceding the fiscal year in which the rate will be paid by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for that year by its average case-mix score determined under section ~~5111.231~~ 5111.232 of the Revised Code for the same calendar year.

(2)(a) ~~Set the maximum cost per case-mix unit for each peer group of nursing facilities specified in rules adopted under division (E) of this section at a percentage above the cost per case-mix unit of the facility in the group that has the group's median medicaid inpatient day for the calendar year preceding the fiscal year in which the rate will be paid, as calculated under division (B)(1) of this section, that is no less than the percentage calculated under division (D)(1) of this section.~~

~~(b)~~ Set the maximum cost per case-mix unit for each peer group of intermediate care facilities for the mentally retarded with more than eight beds specified in rules adopted under division (E) of this section at a percentage above the cost per case-mix unit of the facility in the group that has the group's median medicaid inpatient day for the calendar year preceding the fiscal year in which the rate will be paid, as calculated under

division (B)(1) of this section, that is no less than the percentage calculated under division (D)(2) of this section.

~~(c)~~(b) Set the maximum cost per case-mix unit for each peer group of intermediate care facilities for the mentally retarded with eight or fewer beds specified in rules adopted under division (E) of this section at a percentage above the cost per case-mix unit of the facility in the group that has the group's median medicaid inpatient day for the calendar year preceding the fiscal year in which the rate will be paid, as calculated under division (B)(1) of this section, that is no less than the percentage calculated under division (D)(3) of this section.

~~(d)~~(c) In calculating the maximum cost per case-mix unit under divisions (B)(2)(a) to ~~(c)~~(b) of this section for each peer group, the department shall exclude from its calculations the cost per case-mix unit of any facility in the group that participated in the ~~medical assistance~~ medicaid program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid.

(3) Estimate the rate of inflation for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the employment cost index for total compensation, health services component, published by the United States bureau of labor statistics. If the estimated inflation rate for the eighteen-month period is different from the actual inflation rate for that period, as measured using the same index, the difference shall be added to or subtracted from the inflation rate estimated under division (B)(3) of this section for the following fiscal year.

(4) The department shall not recalculate a maximum cost per case-mix unit under division (B)(2) of this section or a percentage under division (D) of this section based on additional information that it receives after the maximum costs per case-mix unit or percentages are set. The department shall recalculate a maximum cost per case-mix units or percentage only if it made an error in computing the maximum cost per case-mix unit or percentage based on information available at the time of the original calculation.

(C) Each facility's rate for direct care costs shall be determined as follows for each calendar quarter within a fiscal year:

(1) Multiply the lesser of the following by the facility's average case-mix score determined under section ~~5111.231~~ 5111.232 of the Revised Code for the calendar quarter that preceded the immediately preceding calendar quarter:

(a) The facility's cost per case-mix unit for the calendar year preceding the fiscal year in which the rate will be paid, as determined under division (B)(1) of this section;

(b) The maximum cost per case-mix unit established for the fiscal year in which the rate will be paid for the facility's peer group under division (B)(2) of this section;

(2) Adjust the product determined under division (C)(1) of this section by the inflation rate estimated under division (B)(3) of this section.

(D)(1) ~~The department shall calculate the percentage above the median cost per case-mix unit determined under division (B)(1) of this section for the facility that has the median medicaid inpatient day for calendar year 1992 for all nursing facilities that would result in payment of all desk-reviewed, actual, allowable direct care costs for eighty-five per cent of the medicaid inpatient days for nursing facilities for calendar year 1992.~~

~~(2)~~ The department shall calculate the percentage above the median cost per case-mix unit determined under division (B)(1) of this section for the facility that has the median medicaid inpatient day for calendar year 1992 for all intermediate care facilities for the mentally retarded with more than eight beds that would result in payment of all desk-reviewed, actual, allowable direct care costs for eighty and one-half per cent of the medicaid inpatient days for such facilities for calendar year 1992.

~~(3)~~(2) The department shall calculate the percentage above the median cost per case-mix unit determined under division (B)(1) of this section for the facility that has the median medicaid inpatient day for calendar year 1992 for all intermediate care facilities for the mentally retarded with eight or fewer beds that would result in payment of all desk-reviewed, actual, allowable direct care costs for eighty and one-half per cent of the medicaid inpatient days for such facilities for calendar year 1992.

(E) The director of job and family services shall adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code that specify peer groups of ~~nursing facilities,~~ intermediate care facilities for the mentally retarded with more than eight beds~~,~~ and intermediate care facilities for the mentally retarded with eight or fewer beds, based on findings of significant per diem direct care cost differences due to geography and facility bed-size. The rules also may specify peer groups based on findings of significant per diem direct care cost differences due to other factors which may include~~, in the case of intermediate care facilities for the mentally retarded,~~ case-mix.

(F) The department, in accordance with division ~~(C)~~(D) of section ~~5111.231~~ 5111.232 of the Revised Code and rules adopted under division

~~(D)~~(E) of that section, may assign case-mix scores or costs per case-mix unit if a ~~facility~~ provider fails to submit assessment ~~information~~ data necessary to calculate ~~its~~ an intermediate care facility for the mentally retarded's case-mix score in accordance with that section.

Sec. 5111.231. (A) As used in this section, "applicable calendar year" means the following:

(1) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's cost per case-mix unit, calendar year 2003;

(2) For the purpose of the department's subsequent determinations under division (D) of this section of each peer group's cost per case-mix unit, the calendar year the department selects.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for direct care costs determined semi-annually by multiplying the cost per case-mix unit determined under division (D) of this section for the facility's peer group by the facility's semiannual case-mix score determined under section 5111.232 of the Revised Code.

(C) For the purpose of determining nursing facilities' rate for direct care costs, the department shall establish three peer groups.

Each nursing facility located in any of the following counties shall be placed in peer group one: Brown, Butler, Clermont, Clinton, Hamilton, and Warren.

Each nursing facility located in any of the following counties shall be placed in peer group two: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood.

Each nursing facility located in any of the following counties shall be placed in peer group three: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

(D)(1) At least once every ten years, the department shall determine a cost per case-mix unit for each peer group established under division (C) of this section. A cost per case-mix unit determined under this division for a

peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's cost per case-mix unit, the department shall do all of the following:

(a) Determine the cost per case-mix unit for each nursing facility in the peer group for the applicable calendar year by dividing each facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year by the facility's annual average case-mix score determined under section 5111.232 of the Revised Code for the applicable calendar year.

(b) Subject to division (D)(2) of this section, identify which nursing facility in the peer group is at the twenty-fifth percentile of the cost per case-mix units determined under division (D)(1)(a) of this section.

(c) Calculate the amount that is seven per cent above the cost per case-mix unit determined under division (D)(1)(a) of this section for the nursing facility identified under division (D)(1)(b) of this section.

(d) Multiply the amount calculated under division (D)(1)(c) of this section by the rate of inflation for the eighteen-month period beginning on the first day of July of the applicable calendar year and ending the last day of December of the calendar year immediately following the applicable calendar year using the employment cost index for total compensation, health services component, published by the United States bureau of labor statistics.

(2) In making the identification under division (D)(1)(b) of this section, the department shall exclude both of the following:

(a) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(b) Nursing facilities whose direct care costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem direct care cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(3) The department shall not redetermine a peer group's cost per case-mix unit under this division based on additional information that it receives after the peer group's per case-mix unit is determined. The department shall redetermine a peer group's cost per case-mix unit only if it made an error in determining the peer group's cost per case-mix unit based on information available to the department at the time of the original determination.

Sec. ~~5111.231~~ 5111.232. (A)(1) The department of job and family services shall determine semiannual and annual average case-mix scores for nursing facilities by using ~~data for each resident, regardless of payment~~

~~source,~~ all of the following:

(a) Data from a resident assessment instrument specified in rules adopted ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code pursuant to section 1919(e)(5) of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396r(e)(5), as amended, ~~and~~ for the following residents:

(i) When determining semi-annual case-mix scores, each resident who is a medicaid recipient;

(ii) When determining annual average case-mix scores, each resident regardless of payment source.

(b) Except as provided in rules authorized by division (A)(2)(a) and (b) of this section, the case-mix values established by the United States department of health and human services~~. Except~~;

(c) Except as modified in rules ~~adopted under~~ authorized by division (A)~~(1)~~(2)(c) of this section, ~~the department also shall use~~ the grouper methodology used on June 30, 1999, by the United States department of health and human services for prospective payment of skilled nursing facilities under the medicare program established by Title XVIII ~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~. ~~The~~

(2) The director of job and family services may adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code that do any of the following:

(a) Adjust the case-mix values specified in division (A)(1)(b) of this section to reflect changes in relative wage differentials that are specific to this state;

(b) Express all of ~~the~~ those case-mix values in numeric terms that are different from the terms specified by the United States department of health and human services but that do not alter the relationship of the case-mix values to one another;

(c) Modify the grouper methodology specified in division (A)(1)(c) of this section as follows:

(i) Establish a different hierarchy for assigning residents to case-mix categories under the methodology;

(ii) Prohibit the use of the index maximizer element of the methodology;

(iii) Incorporate changes to the methodology the United States department of health and human services makes after June 30, 1999;

(iv) Make other changes the ~~nursing facility reimbursement study council established by section 5111.34 of the Revised Code approves~~ department determines are necessary.

~~(2)~~(B) The department shall determine case-mix scores for intermediate care facilities for the mentally retarded using data for each resident, regardless of payment source, from a resident assessment instrument and grouper methodology prescribed in rules adopted ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code and expressed in case-mix values established by the department in those rules.

~~(B) Not later than fifteen days after the end of each~~ (C) Each calendar quarter, each ~~nursing facility and intermediate care facility for the mentally retarded~~ provider shall ~~submit to the department the~~ compile complete assessment data, from the resident assessment instrument specified in rules ~~adopted under~~ authorized by division (A) or (B) of this section, for each resident of each of the provider's facilities, regardless of payment source, who was in the facility or on hospital or therapeutic leave from the facility on the last day of the quarter. Providers of a nursing facility shall submit the data to the department of health and, if required by rules, the department of job and family services. Providers of an intermediate care facility for the mentally retarded shall submit the data to the department of job and family services. The data shall be submitted not later than fifteen days after the end of the calendar quarter for which the data is compiled.

Except as provided in division ~~(C)~~(D) of this section, the department, every six months and after the end of each calendar year ~~and pursuant to procedures specified in rules adopted in accordance with Chapter 119. of the Revised Code~~, shall calculate ~~an~~ a semiannual and annual average case-mix score for each nursing facility ~~and intermediate care facility for the mentally retarded~~ using the facility's quarterly case-mix scores for that six-month period or calendar year. Also except as provided in division (D) of this section, the department, after the end of each calendar year, shall calculate an annual average case-mix score for each intermediate care facility for the mentally retarded using the facility's quarterly case-mix scores for that calendar year. The department shall make the calculations pursuant to procedures specified in rules adopted under section 5111.02 of the Revised Code.

~~(C)~~(D)(1) If a ~~facility~~ provider does not timely submit information for a calendar quarter necessary to calculate ~~its~~ a facility's case-mix score, or submits incomplete or inaccurate information for a calendar quarter, the department may assign the facility a quarterly average case-mix score that is five per cent less than the facility's quarterly average case-mix score for the preceding calendar quarter. If the facility was subject to an exception review under division (C) of section 5111.27 of the Revised Code for the preceding calendar quarter, the department may assign a quarterly average case-mix

score that is five per cent less than the score determined by the exception review. If the facility was assigned a quarterly average case-mix score for the preceding quarter, the department may assign a quarterly average case-mix score that is five per cent less than that score assigned for the preceding quarter.

The department may use a quarterly average case-mix score assigned under division ~~(C)~~(D)(1) of this section, instead of a quarterly average case-mix score calculated based on the ~~facility's~~ provider's submitted information, to calculate the facility's rate for direct care costs being established under section 5111.23 or 5111.231 of the Revised Code for one or more months, as specified in rules ~~adopted under~~ authorized by division ~~(D)~~(E) of this section, of the quarter for which the rate established under section 5111.23 or 5111.231 of the Revised Code will be paid.

Before taking action under division ~~(C)~~(D)(1) of this section, the department shall permit the ~~facility~~ provider a reasonable period of time, specified in rules ~~adopted under~~ authorized by division ~~(D)~~(E) of this section, to correct the information. In the case of an intermediate care facility for the mentally retarded, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the ~~facility~~ provider fails to submit corrected information prior to the eighty-first day after the end of the calendar quarter to which the information pertains. In the case of a nursing facility, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the ~~facility~~ provider fails to submit corrected information prior to the earlier of the eighty-first day after the end of the calendar quarter to which the information pertains or the deadline for submission of such corrections established by regulations adopted by the United States department of health and human services under Titles XVIII and XIX ~~of the Social Security Act~~.

(2) If a ~~facility~~ provider is paid a rate for a facility calculated using a quarterly average case-mix score assigned under division ~~(C)~~(D)(1) of this section for more than six months in a calendar year, the department may assign the facility a cost per case-mix unit that is five per cent less than the facility's actual or assigned cost per case-mix unit for the preceding calendar year. The department may use the assigned cost per case-mix unit, instead of calculating the facility's actual cost per case-mix unit in accordance with section 5111.23 or 5111.231 of the Revised Code, to establish the facility's rate for direct care costs for the following fiscal year.

(3) The department shall take action under division ~~(C)~~(D)(1) or (2) of this section only in accordance with rules ~~adopted under~~ authorized by

division ~~(D)~~(E) of this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections 5111.27 and 5111.28 of the Revised Code.

~~(D)~~(E) The director ~~may~~ shall adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code that do ~~any~~ all of the following:

(1) Specify whether providers of a nursing facility must submit the assessment data to the department of job and family services;

(2) Specify the medium or media through which the completed assessment ~~information~~ data shall be submitted;

~~(2)~~(3) Establish procedures under which the ~~department will review~~ assessment ~~information~~ data shall be reviewed for accuracy and ~~notify the facility~~ providers shall be notified of any ~~information~~ data that requires correction;

~~(3)~~(4) Establish procedures for ~~facilities~~ providers to correct assessment ~~information. The procedures may prohibit an intermediate care facility for the mentally retarded from submitting corrected assessment information, for the purpose of calculating its annual average case-mix score, more than two calendar quarters after the end of the quarter to which the information pertains or, if the information pertains to the quarter ending the thirty-first day of December, after the thirty-first day of the following March~~ data and specify a reasonable period of time by which providers shall submit the corrections. The procedures may limit the content of corrections by providers of nursing facilities in the manner required by regulations adopted by the United States department of health and human services under Titles XVIII and XIX ~~of the Social Security Act and prohibit a nursing facility from submitting corrected assessment information, for the purpose of calculating its annual average case-mix score, more than the earlier of the following:~~

~~(a) Two calendar quarters after the end of the quarter to which the information pertains or, if the information pertains to the quarter ending the thirty-first day of December, after the thirty-first day of the following March;~~

~~(b) The deadline for submission of such corrections established by regulations adopted by the United States department of health and human services under Titles XVIII and XIX of the Social Security Act~~.

~~(4)~~(5) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division ~~(C)~~(D) of this section if information necessary to calculate the facility's ~~average annual or quarterly~~ case-mix score is not provided or corrected in accordance with the

procedures established by the rules. Notwithstanding any other provision of sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code, the rules also may provide for ~~exclusion~~ the following:

(a) Exclusion of case-mix scores assigned under division ~~(C)~~(D) of this section from calculation of ~~the facility's~~ an intermediate care facility for the mentally retarded's annual average case-mix score and the maximum cost per case-mix unit for the facility's peer group;

(b) Exclusion of case-mix scores assigned under division (D) of this section from calculation of a nursing facility's semiannual or annual average case-mix score and the cost per case-mix unit for the facility's peer group.

Sec. 5111.235. The department of job and family services shall pay a provider for each of the provider's eligible ~~nursing facility and~~ intermediate care ~~facility~~ facilities for the mentally retarded a per resident per day rate for other protected costs established prospectively each fiscal year for each facility. The rate for each facility shall be the facility's desk-reviewed, actual, allowable, per diem other protected costs from the calendar year preceding the fiscal year in which the rate will be paid, all adjusted~~, except for franchise permit fees paid under section 3721.53 of the Revised Code,~~ for the estimated inflation rate for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of that fiscal year. The department shall estimate inflation using the consumer price index for all urban consumers for nonprescription drugs and medical supplies, as published by the United States bureau of labor statistics. If the estimated inflation rate for the eighteen-month period is different from the actual inflation rate for that period, the difference shall be added to or subtracted from the inflation rate estimated for the following year.

Sec. 5111.24. (A) As used in this section, "applicable calendar year" means the following:

(1) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's rate for ancillary and support costs, calendar year 2003;

(2) For the purpose of the department's subsequent determinations under division (D) of this section of each peer group's rate for ancillary and support costs, the calendar year the department selects.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for ancillary and support costs determined for the nursing facility's peer group under division (D) of this section.

(C) For the purpose of determining nursing facilities' rate for ancillary

and support costs, the department shall establish six peer groups.

Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two.

Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four.

Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group six.

(D)(1) At least once every ten years, the department shall determine the rate for ancillary and support costs for each peer group established under division (C) of this section. The rate for ancillary and support costs determined under this division for a peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's rate for ancillary and support costs, the department shall do all of the following:

(a) Determine the rate for ancillary and support costs for each nursing facility in the peer group for the applicable calendar year by using the greater of the nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been ninety per cent.

For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.

(b) Subject to division (D)(2) of this section, identify which nursing facility in the peer group is at the twenty-fifth percentile of the rate for ancillary and support costs for the applicable calendar year determined under division (D)(1)(a) of this section.

(c) Calculate the amount that is three per cent above the rate for ancillary and support costs determined under division (D)(1)(a) of this section for the nursing facility identified under division (D)(1)(b) of this section.

(d) Multiply the amount calculated under division (D)(1)(c) of this section by the rate of inflation for the eighteen-month period beginning on the first day of July of the applicable calendar year and ending the last day of December of the calendar year immediately following the applicable calendar year using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(2) In making the identification under division (D)(1)(b) of this section, the department shall exclude both of the following:

(a) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(b) Nursing facilities whose ancillary and support costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem ancillary and support cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(3) The department shall not redetermine a peer group's rate for ancillary and support costs under this division based on additional information that it receives after the rate is determined. The department shall redetermine a peer group's rate for ancillary and support costs only if it made an error in determining the rate based on information available to the department at the time of the original determination.

Sec. 5111.241. (A) The department of job and family services shall pay a provider for each of the provider's eligible intermediate care ~~facility~~ facilities for the mentally retarded a per resident per day rate for indirect care costs established prospectively each fiscal year for each facility. The rate for each intermediate care facility for the mentally retarded shall be the sum of the following, but shall not exceed the maximum rate established for the facility's peer group under division (B) of this section:

(1) The facility's desk-reviewed, actual, allowable, per diem indirect care costs from the calendar year preceding the fiscal year in which the rate will be paid, adjusted for the inflation rate estimated under division (C)(1) of this section;

(2) An efficiency incentive in the following amount:

(a) For fiscal years ending in even-numbered calendar years:

(i) In the case of intermediate care facilities for the mentally retarded with more than eight beds, seven and one-tenth per cent of the maximum rate established for the facility's peer group under division (B) of this section;

(ii) In the case of intermediate care facilities for the mentally retarded with eight or fewer beds, seven per cent of the maximum rate established for the facility's peer group under division (B) of this section;

(b) For fiscal years ending in odd-numbered calendar years, the amount calculated for the preceding fiscal year under division (A)(2)(a) of this section.

(B)(1) The maximum rate for indirect care costs for each peer group of intermediate care facilities for the mentally retarded with more than eight beds specified in rules adopted under division (D) of this section shall be determined as follows:

(a) For fiscal years ending in even-numbered calendar years, the maximum rate for each peer group shall be the rate that is no less than twelve and four-tenths per cent above the median desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with more than eight beds in the group, excluding facilities in the group whose indirect care costs for that period are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with more than eight beds, for the calendar year preceding the fiscal year in which the rate will be paid, adjusted by the inflation rate estimated under division (C)(1) of this section.

(b) For fiscal years ending in odd-numbered calendar years, the maximum rate for each peer group is the group's maximum rate for the previous fiscal year, adjusted for the inflation rate estimated under division (C)(2) of this section.

(2) The maximum rate for indirect care costs for each peer group of intermediate care facilities for the mentally retarded with eight or fewer beds specified in rules adopted under division (D) of this section shall be determined as follows:

(a) For fiscal years ending in even-numbered calendar years, the

maximum rate for each peer group shall be the rate that is no less than ten and three-tenths per cent above the median desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with eight or fewer beds in the group, excluding facilities in the group whose indirect care costs are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem indirect care cost for all intermediate care facilities for the mentally retarded with eight or fewer beds, for the calendar year preceding the fiscal year in which the rate will be paid, adjusted by the inflation rate estimated under division (C)(1) of this section.

(b) For fiscal years that end in odd-numbered calendar years, the maximum rate for each peer group is the group's maximum rate for the previous fiscal year, adjusted for the inflation rate estimated under division (C)(2) of this section.

(3) The department shall not recalculate a maximum rate for indirect care costs under division (B)(1) or (2) of this section based on additional information that it receives after the maximum rate is set. The department shall recalculate the maximum rate for indirect care costs only if it made an error in computing the maximum rate based on the information available at the time of the original calculation.

(C)(1) When adjusting rates for inflation under divisions (A)(1), (B)(1)(a), and (B)(2)(a) of this section, the department shall estimate the rate of inflation for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(2) When adjusting rates for inflation under divisions (B)(1)(b) and (B)(2)(b) of this section, the department shall estimate the rate of inflation for the twelve-month period beginning on the first day of January of the fiscal year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(3) If an inflation rate estimated under division (C)(1) or (2) of this section is different from the actual inflation rate for the relevant time period, as measured using the same index, the difference shall be added to or subtracted from the inflation rate estimated pursuant to this division for the

following fiscal year.

(D) The director of job and family services shall adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code that specify peer groups of intermediate care facilities for the mentally retarded with more than eight beds, and peer groups of intermediate care facilities for the mentally retarded with eight or fewer beds, based on findings of significant per diem indirect care cost differences due to geography and facility bed-size. The rules also may specify peer groups based on findings of significant per diem indirect care cost differences due to other factors, including case-mix.

Sec. 5111.242. (A) As used in this section:

(1) "Applicable calendar year" means the following:

(a) For the purpose of the department of job and family services' initial determination under this section of nursing facilities' rate for tax costs, calendar year 2003;

(b) For the purpose of the department's subsequent determinations under division (D) of this section of nursing facilities' rate for tax costs, the calendar year the department selects.

(2) "Tax costs" means the costs of taxes imposed under Chapter 5751. of the Revised Code, real estate taxes, personal property taxes, and corporate franchise taxes.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for tax costs determined under division (C) of this section.

(C) At least once every ten years, the department shall determine the rate for tax costs for each nursing facility. The rate for tax costs determined under this division for a nursing facility shall be used for subsequent years until the department redetermines it. To determine a nursing facility's rate for tax costs, the department shall divide the nursing facility's desk-reviewed, actual, allowable tax costs paid for the applicable calendar year by the number of inpatient days the nursing facility would have had if its occupancy rate had been one hundred per cent during the applicable calendar year.

Sec. 5111.243. The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for the franchise permit fees paid for the nursing facility. The rate shall be equal to the franchise permit fee for the fiscal year for which the rate is paid.

Sec. 5111.244. (A) As used in this section, "deficiency" and "standard survey" have the same meanings as in section 5111.35 of the Revised Code.

(B) Each year, the department of job and family services shall pay each nursing facility placed in the first, second, and third quality tier groups established under division (C) of this section a quality incentive payment. Nursing facilities placed in the first group shall receive the highest payment. Nursing facilities placed in the second group shall receive the second highest payment. Nursing facilities placed in the third group shall receive the third highest payment. Nursing facilities placed in the fourth group shall receive no payment. The mean payment, weighted by medicaid days, shall be two per cent of the average rate for all nursing facilities calculated under sections 5111.20 to 5111.33 of the Revised Code, excluding this section. Nursing facilities placed in the fourth group shall be included for the purpose of determining the mean payment.

(C) Each year, the department shall establish four quality tier groups. Each group shall consist of one quarter of all nursing facilities participating in the medicaid program. The first group shall consist of the quarter of nursing facilities individually awarded the most number of points under division (D) of this section. The second group shall consist of the quarter of nursing facilities individually awarded the second most number of points under division (D) of this section. The third group shall consist of the quarter of nursing facilities individually awarded the third most number of points under division (D) of this section. The fourth group shall consist of the quarter of nursing facilities individually awarded the least number of points under division (D) of this section.

(D) Each year, the department shall award each nursing facility participating in the medicaid program one point for each of the following accountability measures the facility meets:

(1) The facility had no health deficiencies on the facility's most recent standard survey.

(2) The facility had no health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards established under Title XIX, on the facility's most recent standard survey.

(3) The facility's resident satisfaction is above the statewide average.

(4) The facility's family satisfaction is above the statewide average.

(5) The number of hours the facility employs nurses is above the statewide average.

(6) The facility's employee retention rate is above the average for the facility's peer group established in division (C) of section 5111.231 of the Revised Code.

(7) The facility's occupancy rate is above the statewide average.

(8) The facility's medicaid utilization rate is above the statewide average.

(9) The facility's case-mix score is above the statewide average.

(E) The director of job and family services shall adopt rules under section 5111.02 of the Revised Code as necessary to implement this section. The rules shall include rules establishing the system for awarding points under division (D) of this section.

Sec. 5111.25. (A) As used in this section, "applicable calendar year" means the following:

(1) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's median rate for capital costs, calendar year 2003;

(2) For the purpose of the department's subsequent determinations under division (D) of this section of each peer group's median rate for capital costs, the calendar year the department selects.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing ~~facility~~ facilities a per resident per day rate for ~~its reasonable~~ capital costs ~~established prospectively each fiscal year for each facility~~. ~~Except as otherwise provided in sections 5111.20 to 5111.32 of the Revised Code, the~~ A nursing facility's rate for capital costs shall be ~~based on~~ the ~~facility's~~ median rate for capital costs for the ~~calendar year preceding the fiscal year in which the rate will be paid~~ nursing facilities in the nursing facility's peer group as determined under division (D) of this section. ~~The rate shall equal the sum of divisions (A)(1) to (3) of this section:~~

~~(1) The lesser of the following:~~

~~(a) Eighty-eight and sixty-five one-hundredths per cent of the facility's desk-reviewed, actual, allowable, per diem cost of ownership and eighty-five per cent of the facility's actual, allowable, per diem cost of nonextensive renovation determined under division (F) of this section;~~

~~(b) Eighty-eight and sixty-five one-hundredths per cent of the following limitation:~~

~~(i) For the fiscal year beginning July 1, 1993, sixteen dollars per resident day;~~

~~(ii) For the fiscal year beginning July 1, 1994, sixteen dollars per resident day, adjusted to reflect the rate of inflation for the twelve-month period beginning July 1, 1992, and ending June 30, 1993, using the consumer price index for shelter costs for all urban consumers for the north central region, published by the United States bureau of labor statistics;~~

~~(iii) For subsequent fiscal years, the limitation in effect during the~~

~~previous fiscal year, adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July for the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the consumer price index for shelter costs for all urban consumers for the north central region, published by the United States bureau of labor statistics.~~

~~(2) Any efficiency incentive determined under division (D) of this section;~~

~~(3) Any amounts for return on equity determined under division (H) of this section~~ (C) For the purpose of determining nursing facilities' rate for capital costs, the department shall establish six peer groups.

Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two.

Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four.

Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group six.

(D)(1) At least once every ten years, the department shall determine the

median rate for capital costs for each peer group established under division (C) of this section. The median rate for capital costs determined under this division for a peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's median rate for capital costs, the department shall do both of the following:

(a) Subject to division (D)(2) of this section, use the greater of each nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been one hundred per cent.

(b) Exclude both of the following:

(i) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(ii) Nursing facilities whose capital costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem capital cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(2) For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity after June 30, 2005, unless the nursing facility also removes the beds from its licensed bed capacity.

(E) Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight-line method over a period designated in rules adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department. Any rules ~~adopted under~~ authorized by this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in ~~cost of ownership or renovation~~ capital costs unless that part of the payment under sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code is used to reimburse the government agency.

~~(B)~~(F) The capital cost basis of nursing facility assets shall be determined in the following manner:

(1) ~~For purposes of calculating the rate to be paid for the fiscal year beginning July 1, 1993, for facilities with dates of licensure on or before June 30, 1993, the capital cost basis shall be equal to the following:~~

~~(a) For facilities that have not had a change of ownership during the period beginning January 1, 1993, and ending June 30, 1993, the desk-reviewed, actual, allowable capital cost basis that is listed on the facility's cost report for the cost reporting period ending December 31, 1992, plus the actual, allowable capital cost basis of any assets constructed or acquired after December 31, 1992, but before July 1, 1993, if the aggregate capital costs of those assets would increase the facility's rate for capital costs by twenty or more cents per resident per day.~~

~~(b) For facilities that have a date of licensure or had a change of ownership during the period beginning January 1, 1993, and ending June 30, 1993, the actual, allowable capital cost basis of the person or government entity that owns the facility on June 30, 1993.~~

~~Capital cost basis shall be calculated as provided in division (B)(1) of this section subject to approval by the United States health care financing administration of any necessary amendment to the state plan for providing medical assistance.~~

~~The department shall include the actual, allowable capital cost basis of assets constructed or acquired during the period beginning January 1, 1993, and ending June 30, 1993, in the calculation for the facility's rate effective July 1, 1993, if the aggregate capital costs of the assets would increase the facility's rate by twenty or more cents per resident per day and the facility provides the department with sufficient documentation of the costs before June 1, 1993. If the facility provides the documentation after that date, the department shall adjust the facility's rate to reflect the costs of the assets one month after the first day of the month after the department receives the documentation.~~

~~(2)~~ Except as provided in division ~~(B)(4)~~(F)(3) of this section, for purposes of calculating the rates to be paid for ~~fiscal years beginning after June 30, 1994, for~~ facilities with dates of licensure on or before June 30, 1993, the capital cost basis of each asset shall be equal to the desk-reviewed, actual, allowable, capital cost basis that is listed on the facility's cost report for the calendar year preceding the fiscal year during which the rate will be paid.

~~(3)~~(2) For facilities with dates of licensure after June 30, 1993, the capital cost basis shall be determined in accordance with the principles of the medicare program established under Title XVIII ~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~, except as otherwise provided in sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code.

~~(4)~~(3) Except as provided in division ~~(B)(5)~~(F)(4) of this section, if a

provider transfers an interest in a facility to another provider after June 30, 1993, there shall be no increase in the capital cost basis of the asset if the providers are related parties or the provider to which the interest is transferred authorizes the provider that transferred the interest to continue to operate the facility under a lease, management agreement, or other arrangement. If the ~~providers are not related parties or if they are related parties and division (B)(5) of this section requires~~ previous sentence does not prohibit the adjustment of the capital cost basis under this division, the basis of the asset shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time that the transferor held the asset, as calculated by the department of job and family services using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time that the transferor held the asset.

~~(5)~~(4) If a provider transfers an interest in a facility to another provider who is a related party, the capital cost basis of the asset shall be adjusted as specified in division ~~(B)(4)~~(F)(3) of this section ~~for a transfer to a provider that is not a related party~~ if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) Except as provided in division ~~(B)(5)~~(F)(4)(c)(ii) of this section, the provider making the transfer retains no ownership interest in the facility;

(c) The department of job and family services determines that the transfer is an arm's length transaction pursuant to rules ~~the department shall adopt in accordance with Chapter 119.~~ adopted under section 5111.02 of the Revised Code ~~no later than December 31, 2000~~. The rules shall provide that a transfer is an arm's length transaction if all of the following apply:

(i) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor.

(ii) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer never occurred when the department calculates its reimbursement rates for capital costs.

(iii) The transfer satisfies any other criteria specified in the rules.

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a provider making the

transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division ~~(B)(5)~~(F)(4) of this section or actual, allowable cost of ownership was determined most recently under division ~~(C)~~(G)(9) of this section.

~~(C)~~(G) As used in this division~~, "lease~~:

"Imputed interest" means the lesser of the prime rate plus two per cent or ten per cent.

"Lease expense" means lease payments in the case of an operating lease and depreciation expense and interest expense in the case of a capital lease. ~~As used in this division, "new~~

"New lease" means a lease, to a different lessee, of a nursing facility that previously was operated under a lease.

(1) Subject to ~~the limitation specified in~~ division ~~(A)(1)~~(B) of this section, for a lease of a facility that was effective on May 27, 1992, the entire lease expense is an actual, allowable capital cost ~~of ownership~~ during the term of the existing lease. The entire lease expense also is an actual, allowable capital cost ~~of ownership~~ if a lease in existence on May 27, 1992, is renewed under either of the following circumstances:

(a) The renewal is pursuant to a renewal option that was in existence on May 27, 1992;

(b) The renewal is for the same lease payment amount and between the same parties as the lease in existence on May 27, 1992.

(2) Subject to ~~the limitation specified in~~ division ~~(A)(1)~~(B) of this section, for a lease of a facility that was in existence but not operated under a lease on May 27, 1992, actual, allowable ~~cost of ownership~~ capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis, adjusted by the lesser of the following amounts:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(3) Subject to ~~the limitation specified in~~ division ~~(A)(1)~~(B) of this section, for a lease of a facility with a date of licensure on or after May 27,

1992, that is initially operated under a lease, actual, allowable ~~cost of ownership~~ capital costs shall include the annual lease expense if there was a substantial commitment of money for construction of the facility after December 22, 1992, and before July 1, 1993. If there was not a substantial commitment of money after December 22, 1992, and before July 1, 1993, actual, allowable ~~cost of ownership~~ capital costs shall include the lesser of the annual lease expense or the sum of the following:

(a) The annual depreciation expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis;

(b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or the imputed interest expense calculated at the inception of the lease using seventy per cent of the lessor's historical capital asset cost basis.

(4) Subject to ~~the limitation specified in~~ division ~~(A)(1)~~(B) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, actual, allowable ~~cost of ownership~~ capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the entire historical capital asset cost basis of the lessor, adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(5) Subject to ~~the limitation specified in~~ division ~~(A)(1)~~(B) of this section, for a new lease of a facility that was operated under a lease on May 27, 1992, actual, allowable ~~cost of ownership~~ capital costs shall include the lesser of the annual new lease expense or the annual old lease payment. If the old lease was in effect for ten years or longer, the old lease payment from the beginning of the old lease shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north

central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

(6) Subject to ~~the limitation specified in~~ division ~~(A)(1)~~(B) of this section, for a new lease of a facility that was not in existence or that was in existence but not operated under a lease on May 27, 1992, actual, allowable ~~cost of ownership~~ capital costs shall include the lesser of annual new lease expense or the annual amount calculated for the old lease under division ~~(C)~~(G)(2), (3), (4), or (6) of this section, as applicable. If the old lease was in effect for ten years or longer, the lessor's historical capital asset cost basis shall be adjusted by the lesser of the following for purposes of calculating the annual amount under division ~~(C)~~(G)(2), (3), (4), or (6) of this section:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

In the case of a lease under division ~~(C)~~(G)(3) of this section of a facility for which a substantial commitment of money was made after December 22, 1992, and before July 1, 1993, the old lease payment shall be adjusted for the purpose of determining the annual amount.

(7) For any revision of a lease described in division ~~(C)~~(G)(1), (2), (3), (4), (5), or (6) of this section, or for any subsequent lease of a facility operated under such a lease, other than execution of a new lease, the portion of actual, allowable ~~cost of ownership~~ capital costs attributable to the lease shall be the same as before the revision or subsequent lease.

(8) Except as provided in division ~~(C)~~(G)(9) of this section, if a provider leases an interest in a facility to another provider who is a related party or previously operated the facility, the related party's or previous operator's actual, allowable ~~cost of ownership~~ capital costs shall include the lesser of the annual lease expense or the reasonable cost to the lessor.

(9) If a provider leases an interest in a facility to another provider who is a related party, regardless of the date of the lease, the related party's actual, allowable ~~cost of ownership~~ capital costs shall include the annual lease expense, subject to the limitations specified in divisions ~~(C)~~(G)(1) to (7) of

this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) If the lessor retains an ownership interest, it is, except as provided in division ~~(C)~~(G)(9)(c)(ii) of this section, in only the real property and any improvements on the real property;

(c) The department of job and family services determines that the lease is an arm's length transaction pursuant to rules ~~the department shall adopt in accordance with Chapter 119.~~ adopted under section 5111.02 of the Revised Code ~~no later than December 31, 2000~~. The rules shall provide that a lease is an arm's length transaction if all of the following apply:

(i) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division ~~(C)~~(G)(9)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(ii) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs.

(iii) The lease satisfies any other criteria specified in the rules.

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division ~~(B)(5)~~(F)(4) of this section or actual, allowable ~~cost of ownership was~~ capital costs were determined most recently under division ~~(C)~~(G)(9) of this section.

(10) This division does not apply to leases of specific items of equipment.

~~(D)(1) Subject to division (D)(2) of this section, the department shall pay each nursing facility an efficiency incentive that is equal to fifty per cent of the difference between the following:~~

~~(a) Eighty-eight and sixty-five one-hundredths per cent of the facility's desk-reviewed, actual, allowable, per diem cost of ownership;~~

~~(b) The applicable amount specified in division (E) of this section.~~

~~(2) The efficiency incentive paid to a nursing facility shall not exceed the greater of the following:~~

~~(a) The efficiency incentive the facility was paid during the fiscal year ending June 30, 1994;~~

~~(b) Three dollars per resident per day, adjusted annually for rates paid beginning July 1, 1994, for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.~~

~~(3) For purposes of calculating the efficiency incentive, depreciation for costs that are paid or reimbursed by any government agency shall be considered as costs of ownership, and renovation costs that are paid under division (F) of this section shall not be considered costs of ownership.~~

~~(E) The following amounts shall be used to calculate efficiency incentives for nursing facilities under this section:~~

~~(1) For facilities with dates of licensure prior to January 1, 1958, four dollars and twenty-four cents per patient day;~~

~~(2) For facilities with dates of licensure after December 31, 1957, but prior to January 1, 1968:~~

~~(a) Five dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;~~

~~(b) Four dollars and twenty-four cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.~~

~~(3) For facilities with dates of licensure after December 31, 1967, but prior to January 1, 1976:~~

~~(a) Six dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;~~

~~(b) Five dollars and twenty-four cents per patient day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeded three thousand five hundred dollars per bed;~~

~~(c) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.~~

~~(4) For facilities with dates of licensure after December 31, 1975, but prior to January 1, 1979:~~

~~(a) Seven dollars and twenty four cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;~~

~~(b) Six dollars and twenty-four cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeded five thousand one hundred fifty dollars per bed;~~

~~(c) Five dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeded three thousand five hundred dollars per bed;~~

~~(d) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.~~

~~(5) For facilities with dates of licensure after December 31, 1978, but prior to January 1, 1981:~~

~~(a) Seven dollars and seventy-four cents per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;~~

~~(b) Seven dollars and twenty-four cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeded six thousand eight hundred dollars per bed;~~

~~(c) Six dollars and twenty-four cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeded five thousand one hundred fifty dollars per bed;~~

~~(d) Five dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeded three thousand five hundred dollars per bed;~~

~~(e) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.~~

~~(6) For facilities with dates of licensure in 1981 or any year thereafter prior to December 22, 1992, the following amount:~~

~~(a) For facilities with construction costs less than seven thousand six hundred twenty-five dollars per bed, the applicable amounts for the construction costs specified in divisions (E)(5)(b) to (e) of this section;~~

~~(b) For facilities with construction costs of seven thousand six hundred twenty-five dollars or more per bed, six dollars per patient day, provided that for 1981 and annually thereafter prior to December 22, 1992, department shall do both of the following to the six-dollar amount:~~

~~(i) Adjust the amount for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, using 1980 as the base year;~~

~~(ii) Increase the amount, as adjusted for inflation under division (E)(6)(b)(i) of this section, by one dollar and seventy-four cents.~~

~~(7) For facilities with dates of licensure on or after January 1, 1992, seven dollars and ninety-seven cents, adjusted for fluctuations in construction costs between 1991 and 1993 as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, and then increased by one dollar and seventy-four cents.~~

~~For the fiscal year that begins July 1, 1994, each of the amounts listed in~~

~~divisions (E)(1) to (7) of this section shall be increased by twenty-five cents. For the fiscal year that begins July 1, 1995, each of those amounts shall be increased by an additional twenty-five cents. For subsequent fiscal years, each of those amounts, as increased for the prior fiscal year, shall be adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.~~

~~If the amount established for a nursing facility under this division is less than the amount that applied to the facility under division (B) of former section 5111.25 of the Revised Code, as the former section existed immediately prior to December 22, 1992, the amount used to calculate the efficiency incentive for the facility under division (D)(2) of this section shall be the amount that was calculated under division (B) of the former section.~~

~~(F) Beginning July 1, 1993, regardless of the facility's date of licensure or the date of the nonextensive renovations, the rate for the costs of nonextensive renovations for nursing facilities shall be eighty-five per cent of the desk-reviewed, actual, allowable, per diem, nonextensive renovation costs. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made nonextensive renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense.~~

~~(1) For a nonextensive renovation made after July 1, 1993, to qualify for payment under this division, both of the following conditions must be met:~~

~~(a) At least five years have elapsed since the date of licensure of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies.~~

~~(b) The provider has obtained prior approval from the department of job and family services, and if required the director of health has granted a certificate of need for the renovation under section 3702.52 of the Revised Code. The provider shall submit a plan that describes in detail the changes in capital assets to be accomplished by means of the renovation and the timetable for completing the project. The time for completion of the project shall be no more than eighteen months after the renovation begins. The department of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code that specify criteria and procedures for~~

~~prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the scope of a project after it is approved by the department of job and family services unless the increase in scope is approved by the department.~~

~~(2) The payment provided for in this division is the only payment that shall be made for the costs of a nonextensive renovation. Nonextensive renovation costs shall not be included in costs of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of calculating the efficiency incentive under divisions (D) and (E) of this section.~~

~~(G) The owner of a nursing facility operating under a provider agreement shall provide written notice to the department of job and family services at least forty-five days prior to entering into any contract of sale for the facility or voluntarily terminating participation in the medical assistance program.~~ (H) After the date on which a transaction of sale is closed, the ~~owner~~ provider shall refund to the department the amount of excess depreciation paid to the provider for the facility by the department for each year the ~~owner~~ provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the ~~facility~~ provider has received payment for the facility. ~~If a nursing facility is sold after five or fewer years of operation under a provider agreement, the refund to the department shall be equal to the excess depreciation paid to the facility. If a nursing facility is sold after more than five years but less than ten years of operation under a provider agreement, the refund to the department shall equal the excess depreciation paid to the facility multiplied by twenty per cent, multiplied by the difference between ten and the number of years that the facility was operated under a provider agreement. If a nursing facility is sold after ten or more years of operation under a provider agreement, the owner shall not refund any excess depreciation to the department.~~ The ~~owner~~ provider of a facility that is sold or that voluntarily terminates participation in the ~~medical assistance~~ medicaid program also shall refund any other amount that the department properly finds to be due after the audit conducted under this division. For the purposes of this division, "depreciation paid to the provider for the facility" means the amount paid to the provider for the nursing facility for ~~cost of ownership~~ capital costs pursuant to this section less any amount paid for interest costs, amortization of financing costs, and lease expenses. For the purposes of this division, "excess depreciation" is the nursing facility's depreciated basis, which is the ~~owner's~~ provider's cost less accumulated depreciation,

subtracted from the purchase price net of selling costs but not exceeding the amount of depreciation paid to the provider for the facility.

~~A cost report shall be filed with the department within ninety days after the date on which the transaction of sale is closed or participation is voluntarily terminated. The report shall show the accumulated depreciation, the sales price, and other information required by the department. The department shall provide for a bank, trust company, or savings and loan association to hold in escrow the amount of the last two monthly payments to a nursing facility made pursuant to division (A)(1) of section 5111.22 of the Revised Code before a sale or termination of participation or, if the owner fails, within the time required by this division, to notify the department before entering into a contract of sale for the facility, the amount of the first two monthly payments made to the facility after the department learns of the contract, regardless of whether a new owner is in possession of the facility. If the amount the owner will be required to refund under this section is likely to be less than the amount of the two monthly payments otherwise put into escrow under this division, the department shall take one of the following actions instead of withholding the amount of the two monthly payments:~~

~~(1) In the case of an owner that owns other facilities that participate in the medical assistance program, obtain a promissory note in an amount sufficient to cover the amount likely to be refunded;~~

~~(2) In the case of all other owners, withhold the amount of the last monthly payment to the nursing facility or, if the owner fails, within the time required by this division, to notify the department before entering into a contract of sale for the facility, the amount of the first monthly payment made to the facility after the department learns of the contract, regardless of whether a new owner is in possession of the facility.~~

~~The department shall, within ninety days following the filing of the cost report, audit the cost report and issue an audit report to the owner. The department also may audit any other cost report that the facility has filed during the previous three years. In the audit report, the department shall state its findings and the amount of any money owed to the department by the nursing facility. The findings shall be subject to adjudication conducted in accordance with Chapter 119. of the Revised Code. No later than fifteen days after the owner agrees to a settlement, any funds held in escrow less any amounts due to the department shall be released to the owner and amounts due to the department shall be paid to the department. If the amounts in escrow are less than the amounts due to the department, the balance shall be paid to the department within fifteen days after the owner~~

~~agrees to a settlement. If the department does not issue its audit report within the ninety-day period, the department shall release any money held in escrow to the owner. For the purposes of this section, a transfer of corporate stock, the merger of one corporation into another, or a consolidation does not constitute a sale.~~

~~If a nursing facility is not sold or its participation is not terminated after notice is provided to the department under this division, the department shall order any payments held in escrow released to the facility upon receiving written notice from the owner that there will be no sale or termination. After written notice is received from a nursing facility that a sale or termination will not take place, the facility shall provide notice to the department at least forty-five days prior to entering into any contract of sale or terminating participation at any future time.~~

~~(H) The department shall pay each eligible proprietary nursing facility a return on the facility's net equity computed at the rate of one and one-half times the average interest rate on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period, except that no facility's return on net equity shall exceed fifty cents per patient day.~~

~~When calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.~~

~~(I) If a nursing facility would receive a lower rate for capital costs for assets in the facility's possession on July 1, 1993, under this section than it would receive under former section 5111.25 of the Revised Code, as the former section existed immediately prior to December 22, 1992, the facility shall receive for those assets the rate it would have received under the former section for each fiscal year beginning on or after July 1, 1993, until the rate it would receive under this section exceeds the rate it would have received under the former section. Any facility that receives a rate calculated under the former section 5111.25 of the Revised Code for assets in the facility's possession on July 1, 1993, also shall receive a rate calculated under this section for costs of any assets it constructs or acquires after July 1, 1993.~~

Sec. 5111.251. (A) The department of job and family services shall pay a provider for each of the provider's eligible intermediate care ~~facility~~ facilities for the mentally retarded for its reasonable capital costs, a per resident per day rate established prospectively each fiscal year for each intermediate care facility for the mentally retarded. Except as otherwise

provided in sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code, the rate shall be based on the facility's capital costs for the calendar year preceding the fiscal year in which the rate will be paid. The rate shall equal the sum of the following:

(1) The facility's desk-reviewed, actual, allowable, per diem cost of ownership for the preceding cost reporting period, limited as provided in divisions (C) and (F) of this section;

(2) Any efficiency incentive determined under division (B) of this section;

(3) Any amounts for renovations determined under division (D) of this section;

(4) Any amounts for return on equity determined under division (I) of this section.

Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight line method over a period designated by the director of job and family services in rules adopted ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department of job and family services. Any rules ~~adopted under~~ authorized by this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in costs of ownership or renovation unless that part of the payment under sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code is used to reimburse the government agency.

(B) The department of job and family services shall pay to a provider for each of the provider's eligible intermediate care ~~facility~~ facilities for the mentally retarded an efficiency incentive equal to fifty per cent of the difference between any desk-reviewed, actual, allowable cost of ownership and the applicable limit on cost of ownership payments under division (C) of this section. For purposes of computing the efficiency incentive, depreciation for costs paid or reimbursed by any government agency shall be considered as a cost of ownership, and the applicable limit under division (C) of this section shall apply both to facilities with more than eight beds and facilities with eight or fewer beds. The efficiency incentive paid to a provider for a facility with eight or fewer beds shall not exceed three dollars per patient day, adjusted annually for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the

calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(C) Cost of ownership payments ~~to~~ for intermediate care facilities for the mentally retarded with more than eight beds shall not exceed the following limits:

(1) For facilities with dates of licensure prior to January 1, l958, not exceeding two dollars and fifty cents per patient day;

(2) For facilities with dates of licensure after December 31, l957, but prior to January 1, l968, not exceeding:

(a) Three dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;

(b) Two dollars and fifty cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.

(3) For facilities with dates of licensure after December 31, l967, but prior to January 1, l976, not exceeding:

(a) Four dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;

(b) Three dollars and fifty cents per patient day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeds three thousand five hundred dollars per bed;

(c) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(4) For facilities with dates of licensure after December 31, l975, but prior to January 1, l979, not exceeding:

(a) Five dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;

(b) Four dollars and fifty cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeds five thousand one hundred fifty dollars per bed;

(c) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeds three thousand five hundred dollars per bed;

(d) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(5) For facilities with dates of licensure after December 31, l978, but prior to January 1, l980, not exceeding:

(a) Six dollars per patient day if the cost of construction was seven

thousand six hundred twenty-five dollars or more per bed;

(b) Five dollars and fifty cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeds six thousand eight hundred dollars per bed;

(c) Four dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeds five thousand one hundred fifty dollars per bed;

(d) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeds three thousand five hundred dollars per bed;

(e) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(6) For facilities with dates of licensure after December 31, 1979, but prior to January 1, 1981, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars per patient day if the beds were originally licensed as nursing home beds by the department of health.

(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and forty-five cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and seventy-nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:

(a) Twelve dollars and twenty-four cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and twenty-three cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(11) For facilities with dates of licensure after December 31, 1984, but prior to January 1, 1986, not exceeding:

(a) Twelve dollars and fifty-three cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and forty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(12) For facilities with dates of licensure after December 31, 1985, but prior to January 1, 1987, not exceeding:

(a) Twelve dollars and seventy cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and fifty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(13) For facilities with dates of licensure after December 31, 1986, but prior to January 1, 1988, not exceeding:

(a) Twelve dollars and ninety-nine cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and sixty-seven cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(14) For facilities with dates of licensure after December 31, 1987, but prior to January 1, 1989, not exceeding thirteen dollars and twenty-six cents per patient day;

(15) For facilities with dates of licensure after December 31, 1988, but prior to January 1, 1990, not exceeding thirteen dollars and forty-six cents per patient day;

(16) For facilities with dates of licensure after December 31, 1989, but prior to January 1, 1991, not exceeding thirteen dollars and sixty cents per patient day;

(17) For facilities with dates of licensure after December 31, 1990, but prior to January 1, 1992, not exceeding thirteen dollars and forty-nine cents per patient day;

(18) For facilities with dates of licensure after December 31, 1991, but prior to January 1, 1993, not exceeding thirteen dollars and sixty-seven cents per patient day;

(19) For facilities with dates of licensure after December 31, 1992, not exceeding fourteen dollars and twenty-eight cents per patient day.

(D) Beginning January 1, 1981, regardless of the original date of licensure, the department of job and family services shall pay a rate for the per diem capitalized costs of renovations to intermediate care facilities for the mentally retarded made after January 1, l981, not exceeding six dollars per patient day using 1980 as the base year and adjusting the amount annually until June 30, 1993, for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift. The payment provided for in this division is the only payment that shall be made for the capitalized costs of a nonextensive renovation of an intermediate care facility for the mentally retarded. Nonextensive renovation costs shall not be included in cost of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of division (C) of this section. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense.

For a nonextensive renovation to qualify for payment under this division, both of the following conditions must be met:

(1) At least five years have elapsed since the date of licensure or date of an extensive renovation of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies.

(2) The provider has obtained prior approval from the department of job and family services. The provider shall submit a plan that describes in detail the changes in capital assets to be accomplished by means of the renovation and the timetable for completing the project. The time for completion of the project shall be no more than eighteen months after the renovation begins. The director of job and family services shall adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code that specify criteria and procedures for prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the

scope of a project after it is approved by the department of job and family services unless the increase in scope is approved by the department.

(E) The amounts specified in divisions (C) and (D) of this section shall be adjusted beginning July 1, 1993, for the estimated inflation for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which rate will be paid and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(F)(1) For facilities of eight or fewer beds that have dates of licensure or have been granted project authorization by the department of mental retardation and developmental disabilities before July 1, 1993, and for facilities of eight or fewer beds that have dates of licensure or have been granted project authorization after that date if the providers of the facilities demonstrate that they made substantial commitments of funds on or before that date, cost of ownership shall not exceed eighteen dollars and thirty cents per resident per day. The eighteen-dollar and thirty-cent amount shall be increased by the change in the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, during the period beginning June 30, 1990, and ending July 1, 1993, and by the change in the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics, annually thereafter.

(2) For facilities with eight or fewer beds that have dates of licensure or have been granted project authorization by the department of mental retardation and developmental disabilities on or after July 1, 1993, for which substantial commitments of funds were not made before that date, cost of ownership payments shall not exceed the applicable amount calculated under division (F)(1) of this section, if the department of job and family services gives prior approval for construction of the facility. If the department does not give prior approval, cost of ownership payments shall not exceed the amount specified in division (C) of this section.

(3) Notwithstanding divisions (D) and (F)(1) and (2) of this section, the total payment for cost of ownership, cost of ownership efficiency incentive, and capitalized costs of renovations for an intermediate care facility for the mentally retarded with eight or fewer beds shall not exceed the sum of the limitations specified in divisions (C) and (D) of this section.

(G) Notwithstanding any provision of this section or section ~~5111.24~~ 5111.241 of the Revised Code, the director of job and family services may adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the

Revised Code that provide for a calculation of a combined maximum payment limit for indirect care costs and cost of ownership for intermediate care facilities for the mentally retarded with eight or fewer beds.

(H) ~~After June 30, 1980, the owner of an intermediate care facility for the mentally retarded operating under a provider agreement shall provide written notice to the department of job and family services at least forty-five days prior to entering into any contract of sale for the facility or voluntarily terminating participation in the medical assistance program.~~ After the date on which a transaction of sale is closed, the ~~owner~~ provider shall refund to the department the amount of excess depreciation paid to the provider for the facility by the department for each year the ~~owner~~ provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the ~~facility~~ provider has received payment for the facility. ~~If an intermediate care facility for the mentally retarded is sold after five or fewer years of operation under a provider agreement, the refund to the department shall be equal to the excess depreciation paid to the facility. If an intermediate care facility for the mentally retarded is sold after more than five years but less than ten years of operation under a provider agreement, the refund to the department shall equal the excess depreciation paid to the facility multiplied by twenty per cent, multiplied by the number of years less than ten that a facility was operated under a provider agreement. If an intermediate care facility for the mentally retarded is sold after ten or more years of operation under a provider agreement, the owner shall not refund any excess depreciation to the department.~~ For the purposes of this division, "depreciation paid to the provider for the facility" means the amount paid to the provider for the intermediate care facility for the mentally retarded for cost of ownership pursuant to this section less any amount paid for interest costs. For the purposes of this division, "excess depreciation" is the intermediate care facility for the mentally retarded's depreciated basis, which is the ~~owner's~~ provider's cost less accumulated depreciation, subtracted from the purchase price but not exceeding the amount of depreciation paid to the provider for the facility.

~~A cost report shall be filed with the department within ninety days after the date on which the transaction of sale is closed or participation is voluntarily terminated for an intermediate care facility for the mentally retarded subject to this division. The report shall show the accumulated depreciation, the sales price, and other information required by the department. The department shall provide for a bank, trust company, or savings and loan association to hold in escrow the amount of the last two~~

~~monthly payments to an intermediate care facility for the mentally retarded made pursuant to division (A)(1) of section 5111.22 of the Revised Code before a sale or voluntary termination of participation or, if the owner fails, within the time required by this division, to notify the department before entering into a contract of sale for the facility, the amount of the first two monthly payments made to the facility after the department learns of the contract, regardless of whether a new owner is in possession of the facility. If the amount the owner will be required to refund under this section is likely to be less than the amount of the two monthly payments otherwise put into escrow under this division, the department shall take one of the following actions instead of withholding the amount of the two monthly payments:~~

~~(1) In the case of an owner that owns other facilities that participate in the medical assistance program, obtain a promissory note in an amount sufficient to cover the amount likely to be refunded;~~

~~(2) In the case of all other owners, withhold the amount of the last monthly payment to the intermediate care facility for the mentally retarded or, if the owner fails, within the time required by this division, to notify the department before entering into a contract of sale for the facility, the amount of the first monthly payment made to the facility after the department learns of the contract, regardless of whether a new owner is in possession of the facility.~~

~~The department shall, within ninety days following the filing of the cost report, audit the report and issue an audit report to the owner. The department also may audit any other cost reports for the facility that have been filed during the previous three years. In the audit report, the department shall state its findings and the amount of any money owed to the department by the intermediate care facility for the mentally retarded. The findings shall be subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code. No later than fifteen days after the owner agrees to a settlement, any funds held in escrow less any amounts due to the department shall be released to the owner and amounts due to the department shall be paid to the department. If the amounts in escrow are less than the amounts due to the department, the balance shall be paid to the department within fifteen days after the owner agrees to a settlement. If the department does not issue its audit report within the ninety-day period, the department shall release any money held in escrow to the owner. For the purposes of this section, a transfer of corporate stock, the merger of one corporation into another, or a consolidation does not constitute a sale.~~

~~If an intermediate care facility for the mentally retarded is not sold or its~~

~~participation is not terminated after notice is provided to the department under this division, the department shall order any payments held in escrow released to the facility upon receiving written notice from the owner that there will be no sale or termination of participation. After written notice is received from an intermediate care facility for the mentally retarded that a sale or termination of participation will not take place, the facility shall provide notice to the department at least forty-five days prior to entering into any contract of sale or terminating participation at any future time.~~

(I) The department of job and family services shall pay a provider for each of the provider's eligible proprietary intermediate care ~~facility~~ facilities for the mentally retarded a return on the facility's net equity computed at the rate of one and one-half times the average of interest rates on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period. No facility's return on net equity paid under this division shall exceed one dollar per patient day.

In calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(J)(1) Except as provided in division (J)(2) of this section, if a provider leases or transfers an interest in a facility to another provider who is a related party, the related party's allowable cost of ownership shall include the lesser of the following:

(a) The annual lease expense or actual cost of ownership, whichever is applicable;

(b) The reasonable cost to the lessor or provider making the transfer.

(2) If a provider leases or transfers an interest in a facility to another provider who is a related party, regardless of the date of the lease or transfer, the related party's allowable cost of ownership shall include the annual lease expense or actual cost of ownership, whichever is applicable, subject to the limitations specified in divisions (B) to (I) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) In the case of a lease, if the lessor retains any ownership interest, it is, except as provided in division (J)(2)(d)(ii) of this section, in only the real property and any improvements on the real property;

(c) In the case of a transfer, the provider making the transfer retains, except as provided in division (J)(2)(d)(iv) of this section, no ownership interest in the facility;

(d) The department of job and family services determines that the lease

or transfer is an arm's length transaction pursuant to rules ~~the department shall adopt in accordance with Chapter 119.~~ adopted under section 5111.02 of the Revised Code ~~no later than December 31, 2000~~. The rules shall provide that a lease or transfer is an arm's length transaction if all of the following, as applicable, apply:

(i) In the case of a lease, once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division (J)(2)(b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(ii) In the case of a lease, the lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs.

(iii) In the case of a transfer, once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor.

(iv) In the case of a transfer, the provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, the department shall treat the facility as if the transfer never occurred when the department calculates its reimbursement rates for capital costs.

(v) The lease or transfer satisfies any other criteria specified in the rules.

(e) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor or provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, allowable cost of ownership was determined most recently under this division.

Sec. 5111.254. (A) The department of job and family services shall establish initial rates for a nursing facility with a first date of licensure that is on or after July 1, 2006, including a facility that replaces one or more existing facilities, or for a nursing facility with a first date of licensure before that date that was initially certified for the medicaid program on or after that date, in the following manner:

(1) The rate for direct care costs shall be the product of the cost per case-mix unit determined under division (D) of section 5111.231 of the

Revised Code for the facility's peer group and the nursing facility's case-mix score. For the purpose of division (A)(1) of this section, the nursing facility's case-mix score shall be the following:

(a) Unless the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the median annual average case-mix score for the nursing facility's peer group;

(b) If the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the semiannual case-mix score most recently determined under section 5111.232 of the Revised Code for the replaced nursing facility as adjusted, if necessary, to reflect any difference in the number of beds in the replaced and replacement nursing facilities.

(2) The rate for ancillary and support costs shall be the rate for the facility's peer group determined under division (D) of section 5111.24 of the Revised Code.

(3) The rate for capital costs shall be the median rate for the facility's peer group determined under division (D) of section 5111.25 of the Revised Code.

(4) The rate for tax costs as defined in section 5111.242 of the Revised Code shall be the median rate for tax costs for the facility's peer group in which the facility is placed under division (C) of section 5111.24 of the Revised Code.

(5) The quality incentive payment shall be the mean payment specified in division (B) of section 5111.244 of the Revised Code.

(B) Subject to division (C) of this section, the department shall adjust the rates established under division (A) of this section effective the first day of July, to reflect new rate calculations for all nursing facilities under sections 5111.20 to 5111.33 of the Revised Code.

(C) If a rate for direct care costs is determined under this section for a nursing facility using the median annual average case-mix score for the nursing facility's peer group, the rate shall be redetermined to reflect the replacement nursing facility's actual semiannual case-mix score determined under section 5111.232 of the Revised Code after the nursing facility submits its first two quarterly assessment data that qualify for use in calculating a case-mix score in accordance with rules authorized by division (E) of section 5111.232 of the Revised Code. If the nursing facility's quarterly submissions do not qualify for use in calculating a case-mix score, the department shall continue to use the median annual average case-mix

score for the nursing facility's peer group in lieu of the nursing facility's semiannual case-mix score until the nursing facility submits two consecutive quarterly assessment data that qualify for use in calculating a case-mix score.

Sec. 5111.255. (A) The department of job and family services shall establish initial rates for ~~a nursing facility or~~ an intermediate care facility for the mentally retarded with a first date of licensure that is on or after January 1, 1993, including a facility that replaces one or more existing facilities, or for ~~a nursing facility or~~ an intermediate care facility for the mentally retarded with a first date of licensure before that date that was initially certified for the ~~medical assistance~~ medicaid program on or after that date, in the following manner:

(1) The rate for direct care costs shall be determined as follows:

(a) If there are no cost or resident assessment data as necessary to calculate a rate under section 5111.23 of the Revised Code, the rate shall be the median cost per case-mix unit calculated under division (B)(1) of that section for the relevant peer group for the calendar year preceding the fiscal year in which the rate will be paid, multiplied by the median annual average case-mix score for the peer group for that period and by the rate of inflation estimated under division (B)~~(5)~~(3) of that section. This rate shall be recalculated to reflect the facility's actual quarterly average case-mix score, in accordance with that section, after it submits its first quarterly assessment ~~information~~ data that qualifies for use in calculating a case-mix score in accordance with rules ~~adopted under~~ authorized by division ~~(D)~~(E) of section ~~5111.231~~ 5111.232 of the Revised Code. If the facility's first two quarterly submissions do not contain assessment ~~information~~ data that qualifies for use in calculating a case-mix score, the department shall continue to calculate the rate using the median annual case-mix score for the peer group in lieu of an assigned quarterly case-mix score. The department shall assign a case-mix score or, if necessary, a cost per case-mix unit under division ~~(C)~~(D) of section ~~5111.231~~ 5111.232 of the Revised Code for any subsequent submissions that do not contain assessment ~~information~~ data that qualifies for use in calculating a case-mix score.

(b) If the facility is a replacement facility and the facility or facilities that are being replaced are in operation immediately before the replacement facility opens, the rate shall be the same as the rate for the replaced facility or facilities, proportionate to the number of beds in each replaced facility. If one or more of the replaced facilities is not in operation immediately before the replacement facility opens, its proportion shall be determined under division (A)(1)(a) of this section.

(2) The rate for other protected costs shall be one hundred fifteen per cent of the median rate for ~~the applicable type of facility~~ intermediate care facilities for the mentally retarded calculated for the fiscal year under section 5111.235 of the Revised Code.

(3) The rate for indirect care costs shall be the applicable maximum rate for the facility's peer group as specified in division (B) of section ~~5111.24 or division (B) of section~~ 5111.241 of the Revised Code.

(4) The rate for capital costs shall be determined under section ~~5111.25 or~~ 5111.251 of the Revised Code using the greater of actual inpatient days or an imputed occupancy rate of eighty per cent.

(B) The department shall adjust the rates established under division (A) of this section at both of the following times:

(1) Effective the first day of July, to reflect new rate calculations for all facilities under sections ~~5111.23~~ 5111.20 to ~~5111.25 and 5111.251~~ 5111.33 of the Revised Code;

(2) Following the ~~facility's~~ provider's submission of ~~its~~ the facility's cost report under division (A)(1)(b) of section 5111.26 of the Revised Code.

The department shall pay the rate adjusted based on the cost report beginning the first day of the calendar quarter that begins more than ninety days after the department receives the cost report.

Sec. 5111.257. If a provider of a nursing facility adds or replaces one or more medicaid certified beds to or at the nursing facility, or renovates one or more of the nursing facility's beds, the rate for the added, replaced, or renovated beds shall be the same as the rate for the nursing facility's existing beds.

Sec. ~~5111.257~~ 5111.258. (A) Notwithstanding sections ~~5111.23, 5111.231, 5111.235, 5111.24, 5111.241, 5111.25, 5111.251, and 5111.255~~ 5111.20 to 5111.33 of the Revised Code, the director of job and family services shall adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code that establish a methodology for calculating the prospective rates ~~for direct care costs, other protected costs, indirect care costs, and capital costs~~ that will be paid each fiscal year to a provider for each of the provider's eligible nursing facilities and intermediate care facilities for the mentally retarded, and discrete units of the provider's nursing facilities or intermediate care facilities for the mentally retarded, that serve residents who have diagnoses or special care needs that require direct care resources that are not measured adequately by the applicable assessment instrument specified in rules ~~adopted under~~ authorized by section ~~5111.231~~ 5111.232 of the Revised Code, or who have diagnoses or special care needs specified in the rules as otherwise qualifying for

consideration under this section. The facilities and units of facilities whose rates are established under this division may include, but shall not be limited to, any of the following:

(1) In the case of nursing facilities, facilities and units of facilities that serve medically fragile pediatric residents, residents who are dependent on ventilators, or residents who have severe traumatic brain injury, end-stage Alzheimer's disease, or end-stage acquired immunodeficiency syndrome;

(2) In the case of intermediate care facilities for the mentally retarded, facilities and units of facilities that serve residents who have complex medical conditions or severe behavioral problems.

The department shall use the methodology established under this division to pay for services rendered by such facilities and units after June 30, 1993.

The rules ~~adopted under~~ authorized by this division shall specify the criteria and procedures the department will apply when designating facilities and units that qualify for calculation of rates under this division. The criteria shall include consideration of whether all of the allowable costs of the facility or unit would be paid by rates established under sections ~~5111.23, 5111.231, 5111.235, 5111.24, 5111.241, 5111.25, 5111.251, and 5111.255~~ 5111.20 to 5111.33 of the Revised Code, and shall establish a minimum bed size for a facility or unit to qualify to have its rates established under this division. The criteria shall not be designed to require that residents be served only in facilities located in large cities. The methodology established by the rules shall consider the historical costs of providing care to the residents of the facilities or units.

The rules may require that a facility designated under this division or containing a unit designated under this division receive authorization from the department to admit or retain a resident to the facility or unit and shall specify the criteria and procedures the department will apply when granting that authorization.

Notwithstanding any other provision of sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code, the costs incurred by facilities or units whose rates are established under this division shall not be considered in establishing payment rates for other facilities or units.

(B) The director may adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code under which the department, notwithstanding any other provision of sections 5111.20 to ~~5111.32~~ 5111.33 of the Revised Code, may adjust the rates determined under sections ~~5111.23~~ 5111.20 to ~~5111.255~~ 5111.33 of the Revised Code for a facility that serves a resident who has a diagnosis or special care need that, in the rules

~~adopted under~~ authorized by division (A) of this section, would qualify a facility or unit of a facility to have its rate determined under that division, but who is not in such a unit. The rules may require that a facility that qualifies for a rate adjustment under this division receive authorization from the department to admit or retain a resident who qualifies the facility for the rate adjustment and shall specify the criteria and procedures the department will apply when granting that authorization.

Sec. 5111.26. (A)(1)(a) Except as provided in division (A)(1)(b) of this section, each ~~nursing facility and intermediate care facility for the mentally retarded~~ provider shall file with the department of job and family services an annual cost report ~~prepared~~ for each of the provider's nursing facilities and intermediate care facilities for the mentally retarded that participate in the medicaid program. A provider shall prepare the reports in accordance with guidelines established by the department. ~~The~~ A report shall cover a calendar year or the portion of a calendar year during which the facility participated in the ~~medical assistance~~ medicaid program. ~~All facilities~~ A provider shall file the reports within ninety days after the end of the calendar year. The department, for good cause, may grant a fourteen-day extension of the time for filing cost reports upon written request from a ~~facility~~ provider. The director of job and family services shall prescribe, in rules adopted ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code, the cost reporting form and a uniform chart of accounts for the purpose of cost reporting, and shall distribute cost reporting forms or computer software for electronic submission of the cost report to each ~~nursing facility and intermediate care facility for the mentally retarded~~ provider at least sixty days before the ~~facility's~~ reporting date.

(b) ~~A facility for which~~ If rates ~~are~~ for a provider's nursing facility or intermediate care facility for the mentally retarded were most recently established under section 5111.254 or 5111.255 of the Revised Code, the provider shall submit a cost report for that facility no later than ninety days after the end of the facility's first three full calendar months of operation. ~~A~~ If a nursing facility or intermediate care facility for the mentally retarded undergoes a change of provider that the department determines, in accordance with rules adopted under section 5111.02 of the Revised Code, is an arm's length transaction, the new provider shall submit a cost report for that facility not later than ninety days after the end of the facility's first three full calendar months of operation under the new provider. The provider of a facility that opens or undergoes a change of provider that is an arm's length transaction after the first day of October in any calendar year is not required to file a cost report for that calendar year.

(c) If a nursing facility undergoes a change of provider that the department determines, in accordance with rules adopted under section 5111.02 of the Revised Code, is not an arms length transaction, the new provider shall file a cost report under division (A)(1)(a) of this section for the facility. The cost report shall cover the portion of the calendar year during which the new provider operated the nursing facility and the portion of the calendar year during which the previous provider operated the nursing facility.

(2) If a ~~nursing facility or intermediate care facility for the mentally retarded~~ provider required to submit a cost ~~reports~~ report for a nursing facility or intermediate care facility for the mentally retarded does not file the ~~reports~~ report within the required time ~~periods~~ period or within fourteen days thereafter if an extension is granted under division (A)(1)(a) of this section, or files an incomplete or inadequate report for the facility, the department shall provide immediate written notice to the ~~facility~~ provider that ~~its~~ the provider agreement for the facility will be terminated in thirty days unless the ~~facility~~ provider submits a complete and adequate cost report for the facility within thirty days. During the thirty-day termination period or any additional time allowed for an appeal of the proposed termination of a provider agreement, the ~~facility~~ provider shall be paid ~~its~~ the facility's then current per resident per day rate, minus two dollars. On July 1, 1994, the department shall adjust the two-dollar reduction to reflect the rate of inflation during the preceding twelve months, as shown in the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics. On July 1, 1995, and the first day of July of each year thereafter, the department shall adjust the amount of the reduction in effect during the previous twelve months to reflect the rate of inflation during the preceding twelve months, as shown in the same index.

(B) No ~~nursing facility or intermediate care facility for the mentally retarded~~ provider shall report fines paid under sections 5111.35 to 5111.62 or section 5111.99 of the Revised Code in any cost report filed under this section.

(C) The department shall develop an addendum to the cost report form that a ~~nursing facility or intermediate care facility for the mentally retarded~~ provider may use to set forth costs that the ~~facility~~ provider believes may be disputed by the department. Any costs reported by the ~~facility~~ provider on the addendum may be considered by the department in setting the facility's rate. If the department does not consider the costs listed on the addendum in setting the facility's rate, the ~~facility~~ provider may seek reconsideration of

that determination under section 5111.29 of the Revised Code. If the department subsequently includes the costs listed in the addendum in the facility's rate, the department shall pay the ~~facility~~ provider interest at a reasonable rate established in rules adopted ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code for the time that the rate paid excluded the costs.

Sec. 5111.261. Except as otherwise provided in ~~sections 5111.262 to~~ section 5111.264 of the Revised Code, the department of job and family services, in determining whether an intermediate care facility for the mentally retarded's direct care costs and indirect care costs are allowable, shall place no limit on specific categories of reasonable costs other than compensation of owners, compensation of relatives of owners, compensation of administrators and costs for resident meals that are prepared and consumed outside the facility.

Compensation cost limits for owners and relatives of owners shall be based on compensation costs for individuals who hold comparable positions but who are not owners or relatives of owners, as reported on facility cost reports. As used in this section, "comparable position" means the position that is held by the owner or the owner's relative, if that position is listed separately on the cost report form, or if the position is not listed separately, the group of positions that is listed on the cost report form and that includes the position held by the owner or the owner's relative. In the case of an owner or owner's relative who serves the facility in a capacity such as corporate officer, proprietor, or partner for which no comparable position or group of positions is listed on the cost report form, the compensation cost limit shall be based on civil service equivalents and shall be specified in rules adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code.

Compensation cost limits for administrators shall be based on compensation costs for administrators who are not owners or relatives of owners, as reported on facility cost reports. Compensation cost limits for administrators of four or more intermediate care facilities for the mentally retarded shall be the same as the limits for administrators of ~~nursing facilities or~~ intermediate care facilities for the mentally retarded with one hundred fifty or more beds.

~~For nursing facilities, cost limits for resident meals that are prepared and consumed outside the facility shall be based on the statewide average cost of serving and preparing meals in all nursing facilities, as reported on the facility cost reports. For intermediate care facilities for the mentally retarded, cost limits for resident meals that are prepared and consumed~~

~~outside the facility shall be based on the statewide average cost of serving and preparing meals in all intermediate care facilities for the mentally retarded, as reported on the facility cost reports.~~

Sec. 5111.263. (A) As used in this section, "covered therapy services" means physical therapy, occupational therapy, audiology, and speech therapy services that are provided by appropriately licensed therapists or therapy assistants and that are covered for nursing facility residents either by the medicare program established under Title XVIII ~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended,~~ or the ~~medical assistance~~ medicaid program as specified in rules adopted by the director of job and family services ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code.

(B) Except as provided in division (G) of this section, the costs of therapy are not allowable costs for nursing facilities for the purpose of determining rates under sections ~~5111.23, 5111.231, 5111.235, 5111.24, 5111.241, 5111.25, 5111.251, 5111.255, and 5111.257~~ 5111.20 to 5111.33 of the Revised Code.

(C) The department of job and family services shall process no claims for payment under the ~~medical assistance~~ medicaid program for covered therapy services rendered to a resident of a nursing facility other than such claims submitted, in accordance with this section, by a nursing facility that has a valid provider agreement with the department.

(D) ~~Nursing~~ Providers of nursing facilities ~~that have entered into a provider agreement~~ may bill the department of job and family services for covered therapy services ~~it provides~~ the nursing facilities provide to residents of any nursing facility who are medicaid recipients ~~of the medical assistance program~~ and not eligible for the medicare program.

(E) The department shall not process any claim for a covered therapy service provided to a nursing facility resident who is eligible for the medicare program unless the claim is for a copayment or deductible or the conditions in division (E)(1) or (2) of this section apply:

(1) The covered therapy service provided is, under the federal statutes, regulations, or policies governing the medicare program, not covered by the medicare program and the service is, under the provisions of this chapter or the rules adopted under this chapter, covered by the ~~medical assistance~~ medicaid program.

(2) All of the following apply:

(a) The individual or entity who provided the covered therapy service was eligible to bill the medicare program for the service.

(b) A complete, accurate, and timely claim was submitted to the

medicare program and the program denied payment for the service as not medically necessary for the resident. For the purposes of division (E)(2)(b) of this section, a claim is not considered to have been denied by the medicare program until either a denial has been issued following a medicare fair hearing or six months have elapsed since the request for a fair hearing was filed.

(c) The facility is required to provide or arrange for the provision of the service by a licensed therapist or therapy assistant to be in compliance with federal or state nursing facility certification requirements for the ~~medical assistance~~ medicaid program.

(d) The claim for payment for the services under the ~~medical assistance~~ medicaid program is accompanied by documentation that divisions (E)(2)(b) and (c) of this section apply to the service.

(F) The reimbursement allowed by the department for covered therapy services provided to nursing facility residents and billed under division (D) or (E) of this section shall be fifteen per cent less than the fees it pays for the same services rendered to hospital outpatients. The director may adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code establishing comparable fees for covered therapy services that are not included in its schedule of fees paid for services rendered to hospital outpatients.

(G) A nursing facility's reasonable costs for rehabilitative, restorative, or maintenance therapy services rendered to facility residents by nurses or nurse aides, and the facility's overhead costs to support provision of therapy services provided to nursing facility residents, are allowable costs for the purposes of establishing rates under sections ~~5111.23, 5111.231, 5111.235, 5111.24, 5111.241, 5111.25, 5111.251, 5111.255, and 5111.257~~ 5111.20 to 5111.33 of the Revised Code.

Sec. 5111.264. Except as provided in section 5111.25 or ~~5111.264~~ 5111.251 of the Revised Code, the costs of goods, services, and facilities, furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party.

Sec. 5111.265. If one or more medicaid-certified beds are relocated from one nursing facility to another nursing facility owned by a different person or government entity and the application for the certificate of need authorizing the relocation is filed with the director of health on or after the effective date of this section, amortization of the cost of acquiring operating rights for the relocated beds is not an allowable cost for the purpose of determining the nursing facility's medicaid reimbursement rate.

Sec. 5111.266. A provider of a nursing facility filing the facility's cost

report with the department of job and family services under section 5111.26 of the Revised Code shall report as a nonreimbursable expense the cost of the nursing facility's franchise permit fee.

Sec. 5111.27. (A) The department of job and family services shall conduct a desk review of each cost report it receives under section 5111.26 of the Revised Code. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. The department shall notify each ~~nursing facility and intermediate care facility for the mentally retarded~~ provider of whether any of ~~its~~ the reported costs are preliminarily determined not to be allowable, the rate calculation under sections ~~5111.23~~ 5111.20 to ~~5111.257~~ 5111.33 of the Revised Code that results from that determination, and the reasons for the determination and resulting rate. The department shall allow the ~~facility~~ provider to verify the calculation and submit additional information.

(B) The department may conduct an audit, as defined by rule adopted ~~by the director of job and family services in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code, of any cost report and shall notify the ~~nursing facility or intermediate care facility for the mentally retarded~~ provider of its findings.

Audits shall be conducted by auditors under contract with or employed by the department. The decision whether to conduct an audit and the scope of the audit, which may be a desk or field audit, shall be determined based on prior performance of the provider and may be based on a risk analysis or other evidence that gives the department reason to believe that the provider has reported costs improperly. A desk or field audit may be performed annually, but is required whenever a provider does not pass the risk analysis tolerance factors. The department shall issue the audit report no later than three years after the cost report is filed, or upon the completion of a desk or field audit on the report or a report for a subsequent cost reporting period, whichever is earlier. During the time within which the department may issue an audit report, the provider may amend the cost report upon discovery of a material error or material additional information. The department shall review the amended cost report for accuracy and notify the provider of its determination.

The department may establish a contract for the auditing of facilities by outside firms. Each contract entered into by bidding shall be effective for one to two years. The department shall establish an audit manual and program which shall require that all field audits, conducted either pursuant to a contract or by department employees:

(1) Comply with the applicable rules prescribed pursuant to Titles XVIII

and XIX ~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended~~;

(2) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants;

(3) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented fairly in accordance with generally accepted accounting principles and department rules, and whether, in all material respects, allowable costs are documented, reasonable, and related to patient care;

(4) Are conducted by accounting firms or auditors who, during the period of the auditors' professional engagement or employment and during the period covered by the cost reports, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(5) Are conducted by accounting firms or auditors who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or auditor;

(6) Are conducted by auditors who are otherwise independent as determined by the standards of independence established by the American institute of certified public accountants;

(7) Are completed within the time period specified by the department;

(8) Provide to the ~~nursing facility or intermediate care facility for the mentally retarded~~ provider complete written interpretations that explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and departmental policies, with explanations and examples, that are sufficient to permit the ~~facility~~ provider to calculate with reasonable certainty those costs that are allowable and the rate to which the provider's facility is entitled.

For the purposes of division (B)(4) of this section, employment of a member of an auditor's family by a nursing facility or intermediate care facility for the mentally retarded that the auditor does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the facility.

(C) The department, pursuant to rules adopted ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code, may conduct an exception review of assessment ~~information~~ data submitted under section ~~5111.231~~ 5111.232 of the Revised Code. The department may conduct an exception review based on the findings of a certification survey conducted by the department of health, a risk analysis, or prior performance of the

provider.

Exception reviews shall be conducted at the facility by appropriate health professionals under contract with or employed by the department of job and family services. The professionals may review resident assessment forms and supporting documentation, conduct interviews, and observe residents to identify any patterns or trends of inaccurate assessments and resulting inaccurate case-mix scores.

The rules shall establish an exception review program that requires that exception reviews do all of the following:

(1) Comply with Titles XVIII and XIX ~~of the "Social Security Act"~~;

(2) Provide a written summary that states whether the resident assessment forms have been completed accurately;

(3) Are conducted by health professionals who, during the period of their professional engagement or employment with the department, neither have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(4) Are conducted by health professionals who, as a condition of their engagement or employment with the department, shall not review any ~~facility~~ provider that has been a client of the professional.

For the purposes of division (C)(3) of this section, employment of a member of a health professional's family by a nursing facility or intermediate care facility for the mentally retarded that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the facility.

If an exception review is conducted before the effective date of the rate that is based on the case-mix ~~information~~ data subject to the review and the review results in findings that exceed tolerance levels specified in the rules adopted under this division, the department, in accordance with those rules, may use the findings to recalculate individual resident case-mix scores, quarterly average facility case-mix scores, and annual average facility case-mix scores. The department may use the recalculated quarterly and annual facility average case-mix scores to calculate the facility's rate for direct care costs for the appropriate calendar quarter or quarters.

(D) The department shall prepare a written summary of any audit disallowance or exception review finding that is made after the effective date of the rate that is based on the cost or case-mix ~~information~~ data. Where the ~~facility~~ provider is pursuing judicial or administrative remedies in good faith regarding the disallowance or finding, the department shall not withhold from the ~~facility's~~ provider's current payments any amounts the

department claims to be due from the ~~facility~~ provider pursuant to section 5111.28 of the Revised Code.

(E) The department shall not reduce rates calculated under sections ~~5111.23~~ 5111.20 to ~~5111.28~~ 5111.33 of the Revised Code on the basis that the ~~facility~~ provider charges a lower rate to any resident who is not eligible for the ~~medical assistance~~ medicaid program.

(F) The department shall adjust the rates calculated under sections ~~5111.23~~ 5111.20 to ~~5111.28~~ 5111.33 of the Revised Code to account for reasonable additional costs that must be incurred by nursing facilities and intermediate care facilities for the mentally retarded to comply with requirements of federal or state statutes, rules, or policies enacted or amended after January 1, 1992, or with orders issued by state or local fire authorities.

Sec. 5111.28. (A) If a provider properly amends its cost report under section 5111.27 of the Revised Code and the amended report shows that the provider received a lower rate under the original cost report than it was entitled to receive, the department of job and family services shall adjust the provider's rate prospectively to reflect the corrected information. The department shall pay the adjusted rate beginning two months after the first day of the month after the provider files the amended cost report. If the department finds, from an exception review of resident assessment information conducted after the effective date of the rate for direct care costs that is based on the assessment information, that inaccurate assessment information resulted in the provider receiving a lower rate than it was entitled to receive, the department prospectively shall adjust the provider's rate accordingly and shall make payments using the adjusted rate for the remainder of the calendar quarter for which the assessment information is used to determine the rate, beginning one month after the first day of the month after the exception review is completed.

(B) If the provider properly amends its cost report under section 5111.27 of the Revised Code, the department makes a finding based on an audit under that section, or the department makes a finding based on an exception review of resident assessment information conducted under that section after the effective date of the rate for direct care costs that is based on the assessment information, any of which results in a determination that the provider has received a higher rate than it was entitled to receive, the department shall recalculate the provider's rate using the revised information. The department shall apply the recalculated rate to the periods when the provider received the incorrect rate to determine the amount of the overpayment. The provider shall refund the amount of the overpayment.

In addition to requiring a refund under this division, the department may charge the provider interest at the applicable rate specified in this division from the time the overpayment was made.

(1) If the overpayment resulted from costs reported for calendar year 1993, the interest shall be no greater than one and one-half times the average bank prime rate.

(2) If the overpayment resulted from costs reported for subsequent calendar years:

(a) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(b) The interest shall be no greater than two and one-half times the current average bank prime rate if the overpayment was greater than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(C) The department also may impose the following penalties:

(1) If a provider does not furnish invoices or other documentation that the department requests during an audit within sixty days after the request, no more than the greater of one thousand dollars per audit or twenty-five per cent of the cumulative amount by which the costs for which documentation was not furnished increased the total medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate;

(2) If an exiting operator or owner fails to provide notice of ~~sale of the~~ a facility ~~or~~ closure, voluntary termination, or voluntary withdrawal of participation in the ~~medical assistance~~ medicaid program~~,~~ as required by section ~~5111.25 or 5111.251~~ 5111.66 of the Revised Code, or an exiting operator or owner and entering operator fail to provide notice of a change of operator as required by section 5111.67 of the Revised Code, no more than the current average bank prime rate plus four per cent of the last two monthly payments.

(D) If the provider continues to participate in the ~~medical assistance~~ medicaid program, the department shall deduct any amount that the provider is required to refund under this section, and the amount of any interest charged or penalty imposed under this section, from the next available payment from the department to the provider. The department and the provider may enter into an agreement under which the amount, together with interest, is deducted in installments from payments from the department to the provider.

(E) The department shall transmit refunds and penalties to the treasurer

of state for deposit in the general revenue fund.

(F) For the purpose of this section, the department shall determine the average bank prime rate using statistical release H.15, "selected interest rates," a weekly publication of the federal reserve board, or any successor publication. If statistical release H.15, or its successor, ceases to contain the bank prime rate information or ceases to be published, the department shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board.

Sec. 5111.29. (A) The director of job and family services shall adopt rules ~~in accordance with Chapter 119.~~ under section 5111.02 of the Revised Code that establish a process under which a ~~nursing facility or intermediate care facility for the mentally retarded~~ provider, or a group or association of ~~facilities~~ providers, may seek reconsideration of rates established under sections ~~5111.23~~ 5111.20 to ~~5111.28~~ 5111.33 of the Revised Code, including a rate for direct care costs recalculated before the effective date of the rate as a result of an exception review of resident assessment information conducted under section 5111.27 of the Revised Code.

(1) Except as provided in divisions (A)(2) to (4) of this section, the only issue that a ~~facility~~ provider, group, or association may raise in the rate reconsideration shall be whether the rate was calculated in accordance with sections ~~5111.23~~ 5111.20 to ~~5111.28~~ 5111.33 of the Revised Code and the rules adopted under ~~those sections~~ section 5111.02 of the Revised Code. The rules shall permit a ~~facility~~ provider, group, or association to submit written arguments or other materials that support its position. The rules shall specify time frames within which the ~~facility~~ provider, group, or association and the department must act. If the department determines, as a result of the rate reconsideration, that the rate established for one or more facilities of a provider is less than the rate to which ~~it~~ the facility is entitled, the department shall increase the rate. If the department has paid the incorrect rate for a period of time, the department shall pay the ~~facility~~ provider the difference between the amount ~~it~~ the provider was paid for that period for the facility and the amount ~~it~~ the provider should have been paid for the facility.

(2) The rules shall provide that during a fiscal year, the department, by means of the rate reconsideration process, may increase ~~a facility's~~ the rate determined for an intermediate care facility for the mentally retarded as calculated under sections ~~5111.23~~ 5111.20 to ~~5111.28~~ 5111.33 of the Revised Code if the provider of the facility demonstrates that ~~its~~ the facility's actual, allowable costs have increased because of extreme circumstances. A facility may qualify for a rate increase only if ~~its~~ the

facility's per diem, actual, allowable costs have increased to a level that exceeds its total rate~~, including any efficiency incentive and return on equity payment~~. The rules shall specify the circumstances that would justify a rate increase under division (A)(2) of this section. ~~In the case of nursing facilities, the~~ The rules shall provide that the extreme circumstances include ~~increased security costs for an inner-city nursing facility and an increase in workers' compensation experience rating of greater than five per cent for a facility that has an appropriate claims management program but do not include a change of ownership that results from bankruptcy, foreclosure, or findings of violations of certification requirements by the department of health. In the case of intermediate care facilities for the mentally retarded, the rules shall provide that the extreme circumstances include, but are not limited to,~~ natural disasters, renovations approved under division (D) of section 5111.251 of the Revised Code, an increase in workers' compensation experience rating of greater than five per cent for a facility that has an appropriate claims management program, increased security costs for an inner-city facility, and a change of ownership that results from bankruptcy, foreclosure, or findings of violations of certification requirements by the department of health. An increase under division (A)(2) of this section is subject to any rate limitations or maximum rates established by sections ~~5111.23~~ 5111.20 to ~~5111.28~~ 5111.33 of the Revised Code for specific cost centers. Any rate increase granted under division (A)(2) of this section shall take effect on the first day of the first month after the department receives the request.

(3) The rules shall provide that the department, through the rate reconsideration process, may increase ~~a facility's~~ an intermediate care facility for the mentally retarded's rate as calculated under sections ~~5111.23~~ 5111.20 to ~~5111.28~~ 5111.33 of the Revised Code if the department, in ~~its~~ the department's sole discretion, determines that the rate as calculated under those sections works an extreme hardship on the facility.

(4) The rules shall provide that when beds certified for the ~~medical assistance~~ medicaid program are added to an existing intermediate care facility~~,~~ for the mentally retarded or replaced at the same site, ~~or subject to a change of ownership or lease,~~ the department, through the rate reconsideration process, shall increase the ~~facility's~~ intermediate care facility for the mentally retarded's rate for capital costs proportionately, as limited by any applicable limitation under section ~~5111.25 or~~ 5111.251 of the Revised Code, to account for the costs of the beds that are added~~,~~ or replaced~~, or subject to a change of ownership or lease~~. The department shall make this increase one month after the first day of the month after the

department receives sufficient documentation of the costs. Any rate increase granted under division (A)(4) of this section after June 30, 1993, shall remain in effect until the effective date of a rate calculated under section ~~5111.25 or~~ 5111.251 of the Revised Code that includes costs incurred for a full calendar year for the bed addition~~,~~ or bed replacement~~, or change of ownership or lease~~. The facility shall report double accumulated depreciation in an amount equal to the depreciation included in the rate adjustment on its cost report for the first year of operation. During the term of any loan used to finance a project for which a rate adjustment is granted under division (A)(4) of this section, if the facility is operated by the same provider, the ~~facility~~ provider shall subtract from the interest costs it reports on its cost report an amount equal to the difference between the following:

(a) The actual, allowable interest costs for the loan during the calendar year for which the costs are being reported;

(b) The actual, allowable interest costs attributable to the loan that were used to calculate the rates paid to the provider for the facility during the same calendar year.

(5) The department's decision at the conclusion of the reconsideration process shall not be subject to any administrative proceedings under Chapter 119. or any other provision of the Revised Code.

(B) ~~Any~~ All of the following are subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code:

(1) Any audit disallowance that the department makes as the result of an audit under section 5111.27 of the Revised Code~~, any~~;

(2) Any adverse finding that results from an exception review of resident assessment information conducted under ~~that~~ section 5111.27 of the Revised Code after the effective date of the facility's rate that is based on the assessment information~~, and any~~;

(3) Any medicaid payment deemed an overpayment under section 5111.683 of the Revised Code;

(4) Any penalty the department imposes under division (C) of section 5111.28 of the Revised Code ~~shall be subject to an adjudication conducted in accordance with Chapter 119.~~ or section 5111.683 of the Revised Code.

Sec. 5111.291. Notwithstanding sections 5111.20 to ~~5111.29~~ 5111.33 of the Revised Code, the department of job and family services may compute the rate for intermediate care facilities for the mentally retarded operated by the department of mental retardation and developmental disabilities or the department of mental health according to the reasonable cost principles of Title XVIII ~~of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395, as amended~~.

Sec. 5111.30. The department of job and family services shall terminate the provider agreement with a ~~nursing facility or intermediate care facility for the mentally retarded~~ provider that does not comply with the requirements of section 3721.071 of the Revised Code for the installation of fire extinguishing and fire alarm systems.

Sec. 5111.31. (A) Every provider agreement with the provider of a nursing facility or intermediate care facility for the mentally retarded shall:

(1) Prohibit the ~~facility~~ provider from failing or refusing to retain as a patient any person because the person is, becomes, or may, as a patient in the facility, become a medicaid recipient ~~of assistance under the medical assistance program~~. For the purposes of this division, a medicaid recipient ~~of medical assistance~~ who is a patient in a facility shall be considered a patient in the facility during any hospital stays totaling less than twenty-five days during any twelve-month period. Recipients who have been identified by the department of job and family services or its designee as requiring the level of care of an intermediate care facility for the mentally retarded shall not be subject to a maximum period of absences during which they are considered patients if prior authorization of the department for visits with relatives and friends and participation in therapeutic programs is obtained under rules adopted under section 5111.02 of the Revised Code.

(2) ~~Include~~ Except as provided by division (B)(1) of this section, include any part of the facility that meets standards for certification of compliance with federal and state laws and rules for participation in the ~~medical assistance~~ medicaid program~~, except that nursing facilities that, during the period beginning July 1, 1987, and ending July 1, 1993, added beds licensed as nursing home beds under Chapter 3721. of the Revised Code are not required to include those beds under a provider agreement unless otherwise required by federal law. Once added to the provider agreement, however, those nursing home beds may not be removed unless the facility withdraws from the medical assistance program in its entirety~~.

(3) Prohibit the ~~facility~~ provider from discriminating against any patient on the basis of race, color, sex, creed, or national origin.

(4) Except as otherwise prohibited under section 5111.55 of the Revised Code, prohibit the ~~facility~~ provider from failing or refusing to accept a patient because the patient is, becomes, or may, as a patient in the facility, become a medicaid recipient ~~of assistance under the medical assistance program~~ if less than eighty per cent of the patients in the facility are medicaid recipients ~~of medical assistance~~.

(B)(1) Except as provided by division (B)(2) of this section, the following are not required to be included in a provider agreement unless

otherwise required by federal law:

(a) Beds added during the period beginning July 1, 1987, and ending July 1, 1993, to a nursing home licensed under Chapter 3721. of the Revised Code;

(b) Beds in an intermediate care facility for the mentally retarded that are designated for respite care under a medicaid waiver component operated pursuant to a waiver sought under section 5111.87 of the Revised Code.

(2) If a provider chooses to include a bed specified in division (B)(1) of this section in a provider agreement, the bed may not be removed from the provider agreement unless the provider withdraws the facility in which the bed is located from the medicaid program.

(C) Nothing in this section shall bar ~~any~~ a provider that is a religious organization operating a religious or denominational nursing facility or intermediate care facility for the mentally retarded ~~that is operated, supervised, or controlled by a religious organization~~ from giving preference to persons of the same religion or denomination. Nothing in this section shall bar any ~~facility~~ provider from giving preference to persons with whom ~~it~~ the provider has contracted to provide continuing care.

~~(C)~~(D) Nothing in this section shall bar ~~any~~ the provider of a county home organized under Chapter 5155. of the Revised Code from admitting residents exclusively from the county in which the county home is located.

~~(D)~~(E) No provider of a nursing facility or intermediate care facility for the mentally retarded ~~with~~ for which a provider agreement is in effect shall violate the provider contract obligations imposed under this section.

~~(E)~~(F) Nothing in divisions (A) and ~~(B)~~(C) of this section shall bar ~~any nursing facility or intermediate care facility for the mentally retarded~~ a provider from retaining patients who have resided in the provider's facility for not less than one year as private pay patients and who subsequently become medicaid recipients ~~of assistance under the medicaid program~~, but refusing to accept as a patient any person who is or may, as a patient in the facility, become a medicaid recipient ~~of assistance under the medicaid program~~, if all of the following apply:

(1) The ~~facility~~ provider does not refuse to retain any patient who has resided in the provider's facility for not less than one year as a private pay patient because the patient becomes a medicaid recipient ~~of assistance under the medicaid program~~, except as necessary to comply with division ~~(E)~~(F)(2) of this section;

(2) The number of medicaid recipients retained under this division does not at any time exceed ten per cent of all the patients in the facility;

(3) On July 1, 1980, all the patients in the facility were private pay

patients.

Sec. 5111.32. Any patient has a cause of action against the provider of a nursing facility or intermediate care facility for the mentally retarded for breach of the provider agreement obligations or other duties imposed by section 5111.31 of the Revised Code. The action may be commenced by the patient, or on ~~his~~ the patient's behalf by ~~his~~ the patient's sponsor or a residents' rights advocate, as either is defined under section 3721.10 of the Revised Code, by the filing of a civil action in the court of common pleas of the county in which the facility is located, or in the court of common pleas of Franklin county.

If the court finds that a breach of the provider agreement obligations imposed by section 5111.31 of the Revised Code has occurred, the court may enjoin the ~~facility~~ provider from engaging in the practice, order such affirmative relief as may be necessary, and award to the patient and a person or public agency that brings an action on behalf of a patient actual damages, costs, and reasonable attorney's fees.

Sec. 5111.33. Reimbursement to ~~nursing facilities and intermediate care facilities for the mentally retarded~~ a provider under sections 5111.20 to 5111.32 of the Revised Code shall include payments to ~~facilities~~ the provider, at a rate equal to the percentage of the per resident per day rates that the department of job and family services has established for the provider's nursing facility or intermediate care facility for the mentally retarded under sections ~~5111.23~~ 5111.20 to ~~5111.29~~ 5111.33 of the Revised Code for the fiscal year for which the cost of services is reimbursed, to reserve a bed for a recipient during a temporary absence under conditions prescribed by the department, to include hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the facility, when the resident's plan of care provides for such absence and federal participation in the payments is available. The maximum period during which payments may be made to reserve a bed shall not exceed the maximum period specified under federal regulations, and shall not be more than thirty days during any calendar year for hospital stays, visits with relatives and friends, and participation in therapeutic programs. Recipients who have been identified by the department as requiring the level of care of an intermediate care facility for the mentally retarded shall not be subject to a maximum period during which payments may be made to reserve a bed if prior authorization of the department is obtained for hospital stays, visits with relatives and friends, and participation in therapeutic programs. The director of job and family services shall adopt rules under ~~division (B) of~~ section 5111.02 of the

Revised Code establishing conditions under which prior authorization may be obtained.

Sec. 5111.34. The director of job and family services shall prepare an annual report containing recommendations on the methodology that should be used to transition paying providers of nursing facilities the rate determined for nursing facilities for one fiscal year to the immediately succeeding fiscal year. The director shall submit a copy of the annual report to the governor, the president and minority leader of the senate, and the speaker and minority leader of the house of representatives not later than the first day of each October.

Sec. 5111.62. The proceeds of all fines, including interest, collected under sections 5111.35 to 5111.62 of the Revised Code shall be deposited in the state treasury to the credit of the residents protection fund, which is hereby created. ~~Moneys~~ The proceeds of all fines, including interest, collected under section 173.42 of the Revised Code shall be deposited in the state treasury to the credit of the residents protection fund.

Moneys in the fund shall be used for the protection of the health or property of residents of nursing facilities in which the department of health finds deficiencies, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for the loss of money managed by the facility under section 3721.15 of the Revised Code. ~~The~~

The fund shall be maintained and administered by the department of job and family services under rules developed in consultation with the departments of health and aging and adopted by the director of job and family services under Chapter 119. of the Revised Code.

Sec. 5111.65. As used in sections 5111.65 to 5111.688 of the Revised Code:

(A) "Change of operator" means an entering operator becoming the operator of a nursing facility or intermediate care facility for the mentally retarded in the place of the exiting operator.

(1) Actions that constitute a change of operator include the following:

(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;

(b) A transfer of all the exiting operator's ownership interest in the operation of the facility to the entering operator, regardless of whether ownership of any or all of the real property or personal property associated with the facility is also transferred;

(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease;

(d) If the exiting operator is a partnership, dissolution of the partnership;

(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:

(i) The change in composition does not cause the partnership's dissolution under state law.

(ii) The partners agree that the change in composition does not constitute a change in operator.

(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

(2) The following, alone, do not constitute a change of operator:

(a) A contract for an entity to manage a nursing facility or intermediate care facility for the mentally retarded as the operator's agent, subject to the operator's approval of daily operating and management decisions;

(b) A change of ownership, lease, or termination of a lease of real property or personal property associated with a nursing facility or intermediate care facility for the mentally retarded if an entering operator does not become the operator in place of an exiting operator;

(c) If the operator is a corporation, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator.

(B) "Effective date of a change of operator" means the day the entering operator becomes the operator of the nursing facility or intermediate care facility for the mentally retarded.

(C) "Effective date of a facility closure" means the last day that the last of the residents of the nursing facility or intermediate care facility for the mentally retarded resides in the facility.

(D) "Effective date of a voluntary termination" means the day the intermediate care facility for the mentally retarded ceases to accept medicaid patients.

(E) "Effective date of a voluntary withdrawal of participation" means the day the nursing facility ceases to accept new medicaid patients other than the individuals who reside in the nursing facility on the day before the effective date of the voluntary withdrawal of participation.

(F) "Entering operator" means the person or government entity that will become the operator of a nursing facility or intermediate care facility for the

mentally retarded when a change of operator occurs.

(G) "Exiting operator" means any of the following:

(1) An operator that will cease to be the operator of a nursing facility or intermediate care facility for the mentally retarded on the effective date of a change of operator;

(2) An operator that will cease to be the operator of a nursing facility or intermediate care facility for the mentally retarded on the effective date of a facility closure;

(3) An operator of an intermediate care facility for the mentally retarded that is undergoing or has undergone a voluntary termination;

(4) An operator of a nursing facility that is undergoing or has undergone a voluntary withdrawal of participation.

(H)(1) "Facility closure" means discontinuance of the use of the building, or part of the building, that houses the facility as a nursing facility or intermediate care facility for the mentally retarded that results in the relocation of all of the facility's residents. A facility closure occurs regardless of any of the following:

(a) The operator completely or partially replacing the facility by constructing a new facility or transferring the facility's license to another facility;

(b) The facility's residents relocating to another of the operator's facilities;

(c) Any action the department of health takes regarding the facility's certification under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended, that may result in the transfer of part of the facility's survey findings to another of the operator's facilities;

(d) Any action the department of health takes regarding the facility's license under Chapter 3721. of the Revised Code;

(e) Any action the department of mental retardation and developmental disabilities takes regarding the facility's license under section 5123.19 of the Revised Code.

(2) A facility closure does not occur if all of the facility's residents are relocated due to an emergency evacuation and one or more of the residents return to a medicaid-certified bed in the facility not later than thirty days after the evacuation occurs.

(I) "Fiscal year," "intermediate care facility for the mentally retarded," "nursing facility," "operator," "owner," and "provider agreement" have the same meanings as in section 5111.20 of the Revised Code.

(J) "Voluntary termination" means an operator's voluntary election to terminate the participation of an intermediate care facility for the mentally

retarded in the medicaid program but to continue to provide service of the type provided by a residential facility as defined in section 5123.19 of the Revised Code.

(K) "Voluntary withdrawal of participation" means an operator's voluntary election to terminate the participation of a nursing facility in the medicaid program but to continue to provide service of the type provided by a nursing facility.

Sec. 5111.651. Sections 5111.65 to 5111.688 of the Revised Code do not apply to a nursing facility or intermediate care facility for the mentally retarded that undergoes a facility closure, voluntary termination, voluntary withdrawal of participation, or change of operator on or before September 30, 2005, if the exiting operator provided written notice of the facility closure, voluntary termination, voluntary withdrawal of participation, or change of operator to the department of job and family services on or before June 30, 2005.

Sec. 5111.66. An exiting operator or owner of a nursing facility or intermediate care facility for the mentally retarded participating in the medicaid program shall provide the department of job and family services written notice of a facility closure, voluntary termination, or voluntary withdrawal of participation not less than ninety days before the effective date of the facility closure, voluntary termination, or voluntary withdrawal of participation. The written notice shall include all of the following:

(A) The name of the exiting operator and, if any, the exiting operator's authorized agent;

(B) The name of the nursing facility or intermediate care facility for the mentally retarded that is the subject of the written notice;

(C) The exiting operator's medicaid provider agreement number for the facility that is the subject of the written notice;

(D) The effective date of the facility closure, voluntary termination, or voluntary withdrawal of participation;

(E) The signature of the exiting operator's or owner's representative.

Sec. 5111.661. An operator shall comply with section 1919(c)(2)(F) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396r(c)(2)(F) if the operator's nursing facility undergoes a voluntary withdrawal of participation.

Sec. 5111.67. (A) An exiting operator or owner and entering operator shall provide the department of job and family services written notice of a change of operator if the nursing facility or intermediate care facility for the mentally retarded participates in the medicaid program and the entering operator seeks to continue the facility's participation. The written notice

shall be provided to the department not later than forty-five days before the effective date of the change of operator if the change of operator does not entail the relocation of residents. The written notice shall be provided to the department not later than ninety days before the effective date of the change of operator if the change of operator entails the relocation of residents. The written notice shall include all of the following:

(1) The name of the exiting operator and, if any, the exiting operator's authorized agent;

(2) The name of the nursing facility or intermediate care facility for the mentally retarded that is the subject of the change of operator;

(3) The exiting operator's medicaid provider agreement number for the facility that is the subject of the change of operator;

(4) The name of the entering operator;

(5) The effective date of the change of operator;

(6) The manner in which the entering operator becomes the facility's operator, including through sale, lease, merger, or other action;

(7) If the manner in which the entering operator becomes the facility's operator involves more than one step, a description of each step;

(8) Written authorization from the exiting operator or owner and entering operator for the department to process a provider agreement for the entering operator;

(9) The signature of the exiting operator's or owner's representative.

(B) The entering operator shall include a completed application for a provider agreement with the written notice to the department. The entering operator shall attach to the application the following:

(1) If the written notice is provided to the department before the date the exiting operator or owner and entering operator complete the transaction for the change of operator, all the proposed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the facility's change of operator;

(2) If the written notice is provided to the department on or after the date the exiting operator or owner and entering operator complete the transaction for the change of operator, copies of all the executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the facility's change of operator.

Sec. 5111.671. The department of job and family services may enter into a provider agreement with an entering operator that goes into effect at 12:01 a.m. on the effective date of the change of operator if all of the following requirements are met:

(A) The department receives a properly completed written notice required by section 5111.67 of the Revised Code on or before the date required by that section.

(B) The entering operator furnishes to the department copies of all the fully executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the change of operator not later than ten days after the effective date of the change of operator.

(C) The entering operator is eligible for medicaid payments as provided in section 5111.21 of the Revised Code.

Sec. 5111.672. (A) The department of job and family services may enter into a provider agreement with an entering operator that goes into effect at 12:01 a.m. on the date determined under division (B) of this section if all of the following are the case:

(1) The department receives a properly completed written notice required by section 5111.67 of the Revised Code.

(2) The entering operator furnishes to the department copies of all the fully executed leases, management agreements, merger agreements and supporting documents, and sales contracts and supporting documents relating to the change of operator.

(3) The requirement of division (A)(1) of this section is met after the time required by section 5111.67 of the Revised Code, the requirement of division (A)(2) of this section is met more than ten days after the effective date of the change of operator, or both.

(4) The entering operator is eligible for medicaid payments as provided in section 5111.21 of the Revised Code.

(B) The department shall determine the date a provider agreement entered into under this section is to go into effect as follows:

(1) The effective date shall give the department sufficient time to process the change of operator, assure no duplicate payments are made, make the withholding required by section 5111.681 of the Revised Code, and withhold the final payment to the exiting operator until one hundred eighty days after either of the following:

(a) The date that the exiting operator submits to the department a properly completed cost report under section 5111.682 of the Revised Code;

(b) The date that the department waives the cost report requirement of section 5111.682 of the Revised Code.

(2) The effective date shall be not earlier than the later of the effective date of the change of operator or the date that the exiting operator or owner and entering operator comply with section 5111.67 of the Revised Code.

(3) The effective date shall be not later than the following after the later of the dates specified in division (B)(2) of this section:

(a) Forty-five days if the change of operator does not entail the relocation of residents;

(b) Ninety days if the change of operator entails the relocation of residents.

Sec. 5111.673. A provider that enters into a provider agreement with the department of job and family services under section 5111.671 or 5111.672 of the Revised Code shall do all of the following:

(A) Comply with all applicable federal statutes and regulations;

(B) Comply with section 5111.22 of the Revised Code and all other applicable state statutes and rules;

(C) Comply with all the terms and conditions of the exiting operator's provider agreement, including, but not limited to, all of the following:

(1) Any plan of correction;

(2) Compliance with health and safety standards;

(3) Compliance with the ownership and financial interest disclosure requirements of 42 C.F.R. 455.104, 455.105, and 1002.3;

(4) Compliance with the civil rights requirements of 45 C.F.R. parts 80, 84, and 90;

(5) Compliance with additional requirements imposed by the department;

(6) Any sanctions relating to remedies for violation of the provider agreement, including deficiencies, compliance periods, accountability periods, monetary penalties, notification for correction of contract violations, and history of deficiencies.

Sec. 5111.674. In the case of a change of operator, the exiting operator shall be considered to be the operator of the nursing facility or intermediate care facility for the mentally retarded for purposes of the medicaid program, including medicaid payments, until the effective date of the entering operator's provider agreement if the provider agreement is entered into under section 5111.671 or 5111.672 of the Revised Code.

Sec. 5111.675. The department of job and family services may enter into a provider agreement as provided in section 5111.22 of the Revised Code, rather than section 5111.671 or 5111.672 of the Revised Code, with an entering operator if the entering operator does not agree to a provider agreement that satisfies the requirements of division (C) of section 5111.673 of the Revised Code. The department may not enter into the provider agreement unless the department of health certifies the nursing facility or intermediate care facility for the mentally retarded under Title XIX of the

"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended. The effective date of the provider agreement shall not precede any of the following:

(A) The date that the department of health certifies the facility;

(B) The effective date of the change of operator;

(C) The date the requirement of section 5111.67 of the Revised Code is satisfied.

Sec. 5111.676. The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code governing adjustments to the medicaid reimbursement rate for a nursing facility or intermediate care facility for the mentally retarded that undergoes a change of operator. No rate adjustment resulting from a change of operator shall be effective before the effective date of the entering operator's provider agreement. This is the case regardless of whether the provider agreement is entered into under section 5111.671, section 5111.672, or, pursuant to section 5111.675, section 5111.22 of the Revised Code.

Sec. 5111.677. Neither of the following shall affect the department of job and family services' determination of whether or when a change of operator occurs or the effective date of an entering operator's provider agreement under section 5111.671, section 5111.672, or, pursuant to section 5111.675, section 5111.22 of the Revised Code:

(A) The department of health's determination that a change of operator has or has not occurred for purposes of licensure under Chapter 3721. of the Revised Code;

(B) The department of mental retardation and developmental disabilities' determination that a change of operator has or has not occurred for purposes of licensure under section 5123.19 of the Revised Code.

Sec. 5111.68. (A) On receipt of a written notice under section 5111.66 of the Revised Code of a facility closure, voluntary termination, or voluntary withdrawal of participation or a written notice under section 5111.67 of the Revised Code of a change of operator, the department of job and family services shall determine the amount of any overpayments made under the medicaid program to the exiting operator, including overpayments the exiting operator disputes, and other actual and potential debts the exiting operator owes or may owe to the department and United States centers for medicare and medicaid services under the medicaid program. In determining the exiting operator's other actual and potential debts to the department under the medicaid program, the department shall include all of the following that the department determines is applicable:

(1) Refunds due the department under section 5111.27 of the Revised

Code;

(2) Interest owed to the department and United States centers for medicare and medicaid services;

(3) Final civil monetary and other penalties for which all right of appeal has been exhausted;

(4) Money owed the department and United States centers for medicare and medicaid services from any outstanding final fiscal audit, including a final fiscal audit for the last fiscal year or portion thereof in which the exiting operator participated in the medicaid program.

(B) If the department is unable to determine the amount of the overpayments and other debts for any period before the effective date of the entering operator's provider agreement or the effective date of the facility closure, voluntary termination, or voluntary withdrawal of participation, the department shall make a reasonable estimate of the overpayments and other debts for the period. The department shall make the estimate using information available to the department, including prior determinations of overpayments and other debts.

Sec. 5111.681. (A) Except as provided in division (B) of this section, the department of job and family services shall withhold the greater of the following from payment due an exiting operator under the medicaid program:

(1) The total amount of any overpayments made under the medicaid program to the exiting operator, including overpayments the exiting operator disputes, and other actual and potential debts, including any unpaid penalties, the exiting operator owes or may owe to the department and United States centers for medicare and medicaid services under the medicaid program;

(2) An amount equal to the average amount of monthly payments to the exiting operator under the medicaid program for the twelve-month period immediately preceding the month that includes the last day the exiting operator's provider agreement is in effect or, in the case of a voluntary withdrawal of participation, the effective date of the voluntary withdrawal of participation.

(B) The department may choose not to make the withholding under division (A) of this section if an entering operator does both of the following:

(1) Enters into a nontransferable, unconditional, written agreement with the department to pay the department any debt the exiting operator owes the department under the medicaid program;

(2) Provides the department a copy of the entering operator's balance

sheet that assists the department in determining whether to make the withholding under division (A) of this section.

Sec. 5111.682. (A) Except as provided in division (B) of this section, an exiting operator shall file with the department of job and family services a cost report not later than ninety days after the last day the exiting operator's provider agreement is in effect or, in the case of a voluntary withdrawal of participation, the effective date of the voluntary withdrawal of participation. The cost report shall cover the period that begins with the day after the last day covered by the operator's most recent previous cost report required by section 5111.26 of the Revised Code and ends on the last day the exiting operator's provider agreement is in effect or, in the case of a voluntary withdrawal of participation, the effective date of the voluntary withdrawal of participation. The cost report shall include, as applicable, all of the following:

(1) The sale price of the nursing facility or intermediate care facility for the mentally retarded;

(2) A final depreciation schedule that shows which assets are transferred to the buyer and which assets are not transferred to the buyer;

(3) Any other information the department requires.

(B) The department, at its sole discretion, may waive the requirement that an exiting operator file a cost report in accordance with division (A) of this section.

Sec. 5111.683. If an exiting operator required by section 5111.682 of the Revised Code to file a cost report with the department of job and family services fails to file the cost report in accordance with that section, all payments under the medicaid program for the period the cost report is required to cover are deemed overpayments until the date the department receives the properly completed cost report. The department may impose on the exiting operator a penalty of one hundred dollars for each calendar day the properly completed cost report is late.

Sec. 5111.684. The department of job and family services may not provide an exiting operator final payment under the medicaid program until the department receives all properly completed cost reports the exiting operator is required to file under sections 5111.26 and 5111.682 of the Revised Code.

Sec. 5111.685. The department of job and family services shall determine the actual amount of debt an exiting operator owes the department under the medicaid program by completing all final fiscal audits not already completed and performing all other appropriate actions the department determines to be necessary. The department shall issue a debt summary

report on this matter not later than ninety days after the date the exiting operator files the properly completed cost report required by section 5111.682 of the Revised Code with the department or, if the department waives the cost report requirement for the exiting operator, ninety days after the date the department waives the cost report requirement. The report shall include the department's findings and the amount of debt the department determines the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program. Only the parts of the report that are subject to an adjudication as specified in section 5111.30 of the Revised Code are subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code.

Sec. 5111.686. The department of job and family services shall release the actual amount withheld under division (A) of section 5111.681 of the Revised Code, less any amount the exiting operator owes the department and United States centers for medicare and medicaid services under the medicaid program, as follows:

(A) Ninety-one days after the date the exiting operator files a properly completed cost report required by section 5111.682 of the Revised Code unless the department issues the report required by section 5111.685 of the Revised Code not later than ninety days after the date the exiting operator files the properly completed cost report;

(B) Not later than thirty days after the exiting operator agrees to a final fiscal audit resulting from the report required by section 5111.685 of the Revised Code if the department issues the report not later than ninety days after the date the exiting operator files a properly completed cost report required by section 5111.682 of the Revised Code;

(C) Ninety-one days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code unless the department issues the report required by section 5111.685 of the Revised Code not later than ninety days after the date the department waives the cost report requirement;

(D) Not later than thirty days after the exiting operator agrees to a final fiscal audit resulting from the report required by section 5111.685 of the Revised Code if the department issues the report not later than ninety days after the date the department waives the cost report requirement of section 5111.682 of the Revised Code.

Sec. 5111.687. The department of job and family services, at its sole discretion, may release the amount withheld under division (A) of section 5111.681 of the Revised Code if the exiting operator submits to the department written notice of a postponement of a change of operator,

facility closure, voluntary termination, or voluntary withdrawal of participation and the transactions leading to the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation are postponed for at least thirty days but less than ninety days after the date originally proposed for the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation as reported in the written notice required by section 5111.66 or 5111.67 of the Revised Code. The department shall release the amount withheld if the exiting operator submits to the department written notice of a cancellation or postponement of a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation and the transactions leading to the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation are canceled or postponed for more than ninety days after the date originally proposed for the change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation as reported in the written notice required by section 5111.66 or 5111.67 of the Revised Code.

After the department receives a written notice regarding a cancellation or postponement of a facility closure, voluntary termination, or voluntary withdrawal of participation, the exiting operator or owner shall provide new written notice to the department under section 5111.66 of the Revised Code regarding any transactions leading to a facility closure, voluntary termination, or voluntary withdrawal of participation at a future time. After the department receives a written notice regarding a cancellation or postponement of a change of operator, the exiting operator or owner and entering operator shall provide new written notice to the department under section 5111.67 of the Revised Code regarding any transactions leading to a change of operator at a future time.

Sec. 5111.688. The director of job and family services may adopt rules under section 5111.02 of the Revised Code to implement sections 5111.65 to 5111.688 of the Revised Code, including rules applicable to an exiting operator that provides written notification under section 5111.66 of the Revised Code of a voluntary withdrawal of participation. Rules adopted under this section shall comply with section 1919(c)(2)(F) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396r(c)(2)(F), regarding restrictions on transfers or discharges of nursing facility residents in the case of a voluntary withdrawal of participation. The rules may prescribe a medicaid reimbursement methodology and other procedures that are applicable after the effective date of a voluntary withdrawal of participation that differ from the reimbursement methodology and other procedures that

would otherwise apply.

Sec. 5111.85. (A) As used in this section and sections 5111.851 to 5111.856 of the Revised Code, "medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under section 1115 or 1915 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1315 or 1396n. "Medicaid waiver component" does not include a care management system established under section 5111.16 of the Revised Code.

(B) The director of job and family services may adopt rules under Chapter 119. of the Revised Code governing medicaid waiver components that establish all of the following:

(1) Eligibility requirements for the medicaid waiver components;

(2) The type, amount, duration, and scope of services the medicaid waiver components provide;

(3) The conditions under which the medicaid waiver components cover services;

(4) The amount the medicaid waiver components pay for services or the method by which the amount is determined;

(5) The manner in which the medicaid waiver components pay for services;

(6) Safeguards for the health and welfare of medicaid recipients receiving services under a medicaid waiver component;

(7) Procedures for enforcing the rules, including establishing corrective action plans for, and imposing financial and administrative sanctions on, persons and government entities that violate the rules. Sanctions shall include terminating medicaid provider agreements. The procedures shall include due process protections.

(8) Other policies necessary for the efficient administration of the medicaid waiver components.

(C) The director of job and family services may adopt different rules for the different medicaid waiver components. The rules shall be consistent with the terms of the waiver authorizing the medicaid waiver component.

~~(D) The director of job and family services may conduct reviews of the medicaid waiver components. The reviews may include physical inspections of records and sites where services are provided under the medicaid waiver components and interviews of providers and recipients of the services. If the director determines pursuant to a review that a person or government entity has violated a rule governing a medicaid waiver component, the director may establish a corrective action plan for the violator and impose fiscal, administrative, or both types of sanctions on the violator in accordance with~~

~~rules adopted under division (B) of this section.~~

Sec. 5111.851. (A) As used in sections 5111.851 to 5111.855 of the Revised Code:

"Administrative agency" means, with respect to a home and community-based services medicaid waiver component, the department of job and family services or, if a state agency or political subdivision contracts with the department under section 5111.91 of the Revised Code to administer the component, that state agency or political subdivision.

"Home and community-based services medicaid waiver component" means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital, nursing facility, or intermediate care facility for the mentally retarded services.

"Hospital" has the same meaning as in section 3727.01 of the Revised Code.

"Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code.

"Level of care determination" means a determination of whether an individual needs the level of care provided by a hospital, nursing facility, or intermediate care facility for the mentally retarded and whether the individual, if determined to need that level of care, would receive hospital, nursing facility, or intermediate care facility for the mentally retarded services if not for a home and community-based services medicaid waiver component.

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

"Skilled nursing facility" means a facility certified as a skilled nursing facility under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

(B) The following requirements apply to each home and community-based services medicaid waiver component:

(1) Only an individual who qualifies for a component shall receive that component's services.

(2) A level of care determination shall be made as part of the process of determining whether an individual qualifies for a component and shall be made each year after the initial determination if, during such a subsequent year, the administrative agency determines there is a reasonable indication that the individual's needs have changed.

(3) A written plan of care or individual service plan based on an individual assessment of the services that an individual needs to avoid needing admission to a hospital, nursing facility, or intermediate care

facility for the mentally retarded shall be created for each individual determined eligible for a component.

(4) Each individual determined eligible for a component shall receive that component's services in accordance with the individual's level of care determination and written plan of care or individual service plan.

(5) No individual may receive services under a component while the individual is a hospital inpatient or resident of a skilled nursing facility, nursing facility, or intermediate care facility for the mentally retarded.

(6) No individual may receive prevocational, educational, or supported employment services under a component if the individual is eligible for such services that are funded with federal funds provided under 29 U.S.C. 730 or the "Individuals with Disabilities Education Act," 111 Stat. 37 (1997), 20 U.S.C. 1400, as amended.

(7) Safeguards shall be taken to protect the health and welfare of individuals receiving services under a component, including safeguards established in rules adopted under section 5111.85 of the Revised Code and safeguards established by licensing and certification requirements that are applicable to the providers of that component's services.

(8) No services may be provided under a component by a provider that is subject to standards that 42 U.S.C. 1382e(e)(1) requires be established if the provider fails to comply with the standards applicable to the provider.

(9) Individuals determined to be eligible for a component, or such individuals' representatives, shall be informed of that component's services, including any choices that the individual or representative may make regarding the component's services, and given the choice of either receiving services under that component or, as appropriate, hospital, nursing facility, or intermediate care facility for the mentally retarded services.

Sec. 5111.852. The department of job and family services may review and approve, modify, or deny written plans of care and individual service plans that section 5111.851 of the Revised Code requires be created for individuals determined eligible for a home and community-based services medicaid waiver component. If a state agency or political subdivision contracts with the department under section 5111.91 of the Revised Code to administer a home and community-based services medicaid waiver component and approves, modifies, or denies a written plan of care or individual service plan pursuant to the agency's or subdivision's administration of the component, the department may review the agency's or subdivision's approval, modification, or denial and order the agency or subdivision to reverse or modify the approval, modification, or denial. The state agency or political subdivision shall comply with the department's

order.

The department of job and family services shall be granted full and immediate access to any records the department needs to implement its duties under this section.

Sec. 5111.853. Each administrative agency shall maintain, for a period of time the department of job and family services shall specify, financial records documenting the costs of services provided under the home and community-based services medicaid waiver components that the agency administers, including records of independent audits. The administrative agency shall make the financial records available on request to the United States secretary of health and human services, United States comptroller general, and their designees.

Sec. 5111.854. Each administrative agency is financially accountable for funds expended for services provided under the home and community-based services medicaid waiver components that the agency administers.

Sec. 5111.855. Each state agency and political subdivision that enters into a contract with the department of job and family services under section 5111.91 of the Revised Code to administer a home and community-based services medicaid waiver component, or one or more aspects of such a component, shall provide the department a written assurance that the agency or subdivision will not violate any of the requirements of sections 5111.85 to 5111.854 of the Revised Code.

Sec. 5111.856. To the extent necessary for the efficient and economical administration of medicaid waiver components, the department of job and family services may transfer an individual enrolled in a medicaid waiver component administered by the department to another medicaid waiver component the department administers if the individual is eligible for the medicaid waiver component and the transfer does not jeopardize the individual's health or safety.

Sec. ~~5111.97~~ 5111.86. (A) As used in this section:

(1) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(2) "Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

(3) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(4) "Ohio home care program" means the program the department of job and family services administers that provides state plan services and medicaid waiver component services pursuant to rules adopted under

sections 5111.01 and 5111.02 of the Revised Code and a medicaid waiver that went into effect July 1, 1998.

(B) The director of job and family services may submit ~~a request~~ requests to the United States secretary of health and human services pursuant to section 1915 of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396n, as amended, to obtain waivers of federal medicaid requirements that would otherwise be violated in the creation and implementation of two or more medicaid waiver components under which home and community-based services ~~programs to replace the Ohio home care program being operated pursuant to rules adopted under sections 5111.01 and 5111.02 of the Revised Code and a medicaid waiver granted prior to the effective date of this section~~ are provided to eligible individuals who need the level of care provided by a nursing facility or hospital. In the ~~request~~ requests, the director may specify the following:

(1) ~~That one of the replacement programs will provide home and community-based services to individuals in need of nursing facility care, including individuals enrolled in the Ohio home care program;~~

~~(2) That the other replacement program will provide services to individuals in need of hospital care, including individuals enrolled in the Ohio home care program;~~

~~(3) That there will be a~~ The maximum number of individuals who may be enrolled in ~~the replacement programs in addition to the number of individuals to be transferred from the Ohio home care program~~ each of the medicaid waiver components included in the requests;

~~(4) That there will be a~~ (2) The maximum amount the ~~department~~ medicaid program may expend each year for each individual enrolled in the ~~replacement programs~~ medicaid waiver components;

~~(5) That there will be a~~ (3) The maximum ~~aggregate~~ amount the ~~department~~ medicaid program may expend each year for all individuals enrolled in the ~~replacement programs~~ medicaid waiver components;

~~(6)~~(4) Any other ~~requirement~~ requirements the director selects for the ~~replacement programs~~ medicaid waiver components.

~~(B)~~(C) If the secretary ~~grants~~ approves the medicaid waivers requested under this section, the director may create and implement the ~~replacement programs~~ medicaid waiver components in accordance with the provisions of the approved waivers ~~granted~~. The department of job and family services shall administer the ~~replacement programs~~ medicaid waiver components.

~~As the replacement programs are implemented, the director shall reduce the maximum number of individuals who may be enrolled in the Ohio home care program by the number of individuals who are transferred to the~~

~~replacement programs. When all individuals who are eligible to be transferred to the replacement programs have been transferred, the director may submit to the secretary an amendment to the state medicaid plan to provide for the elimination of the Ohio home care program.~~

After the first of any medicaid waiver components created under this section begins to enroll eligible individuals, the director may submit to the United States secretary of health and human services an amendment to a medicaid waiver component of the Ohio home care program authorizing the department to cease enrolling additional individuals in that medicaid waiver component of the Ohio home care program. If the secretary approves the amendment, the director may cease to enroll additional individuals in that medicaid waiver component of the Ohio home care program.

Sec. 5111.87. (A) As used in this section and section 5111.871 of the Revised Code~~, "intermediate~~:

(1) "Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code.

(2) "Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

(B) The director of job and family services may apply to the United States secretary of health and human services for both of the following:

(1) One or more medicaid ~~waivers~~ waiver components under which home and community-based services are provided to individuals with mental retardation or other developmental disability as an alternative to placement in an intermediate care facility for the mentally retarded;

(2) One or more medicaid ~~waivers~~ waiver components under which home and community-based services are provided in the form of ~~either or both~~ any of the following:

(a) Early intervention and supportive services for children under three years of age ~~that are provided or arranged by county boards of mental retardation and~~ who have developmental delays or disabilities the director determines are significant;

(b) Therapeutic services for children who have autism ~~and are under six years of age at the time of enrollment~~;

(c) Specialized habilitative services for individuals who are eighteen years of age or older and have autism.

(C) No medicaid waiver component authorized by division (B)(2)(b) or (c) of this section shall provide services that are available under another medicaid waiver component. No medicaid waiver component authorized by division (B)(2)(b) of this section shall provide services to an individual that the individual is eligible to receive through an individualized education

program as defined in section 3323.01 of the Revised Code.

(D) The director of mental retardation and developmental disabilities or director of health may request that the director of job and family services apply for one or more medicaid waivers under this section.

~~(D)~~(E) Before applying for a waiver under this section, the director of job and family services shall seek, accept, and consider public comments.

Sec. 5111.871. The department of job and family services shall enter into a contract with the department of mental retardation and developmental disabilities under section 5111.91 of the Revised Code with regard to one or more of the components of the medicaid program established by the department of job and family services under one or more of the medicaid waivers sought under section 5111.87 of the Revised Code. The contract shall provide for the department of mental retardation and developmental disabilities to administer the components in accordance with the terms of the waivers. The directors of job and family services and mental retardation and developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing the components.

If the department of mental retardation and developmental disabilities or the department of job and family services denies an individual's application for home and community-based services provided under any of these medicaid components, the department that denied the services shall give timely notice to the individual that the individual may request a hearing under section 5101.35 of the Revised Code.

The departments of mental retardation and developmental disabilities and job and family services may approve, reduce, deny, or terminate a service included in the individualized service plan developed for a medicaid recipient eligible for home and community-based services provided under any of these medicaid components. The departments shall consider the recommendations a county board of mental retardation and developmental disabilities makes under division (A)(1)(c) of section 5126.055 of the Revised Code. If either department approves, reduces, denies, or terminates a service, that department shall give timely notice to the medicaid recipient that the recipient may request a hearing under section 5101.35 of the Revised Code.

If supported living or residential services, as defined in section 5126.01 of the Revised Code, are to be provided under any of these components, any person or government entity with a current, valid medicaid provider agreement and a current, valid license under section 5123.19 or certificate under section ~~5123.045~~ 5123.16 or 5126.431 of the Revised Code may provide the services.

Sec. 5111.88. (A) As used in sections 5111.88 to 5111.8812 of the Revised Code:

"Administrative agency" means the department of job and family services or, if the department assigns the day-to-day administration of the ICF/MR conversion pilot program to the department of mental retardation and developmental disabilities pursuant to section 5111.887 of the Revised Code, the department of mental retardation and developmental disabilities.

"ICF/MR conversion pilot program" means the medicaid waiver component authorized by a waiver sought under division (B)(1) of this section.

"ICF/MR services" means intermediate care facility for the mentally retarded services covered by the medicaid program that an intermediate care facility for the mentally retarded provides to a resident of the facility who is a medicaid recipient eligible for medicaid-covered intermediate care facility for the mentally retarded services.

"Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code.

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

(B) By July 1, 2006, or as soon thereafter as practical, but not later than January 1, 2007, the director of job and family services shall, after consulting with and receiving input from the ICF/MR conversion advisory council, submit both of the following to the United States secretary of health and human services:

(1) An application for a waiver authorizing the ICF/MR conversion pilot program under which intermediate care facilities for the mentally retarded, other than such facilities operated by the department of mental retardation and developmental disabilities, may volunteer to convert from providing intermediate care facility for the mentally retarded services to providing home and community-based services and individuals with mental retardation or a developmental disability who are eligible for ICF/MR services may volunteer to receive instead home and community-based services;

(2) An amendment to the state medicaid plan to authorize the director, beginning on the first day that the ICF/MR conversion pilot program begins implementation under section 5111.882 of the Revised Code and except as provided by section 5111.8811 of the Revised Code, to refuse to enter into or amend a medicaid provider agreement with the operator of an intermediate care facility for the mentally retarded if the provider agreement or amendment would authorize the operator to receive medicaid payments

for more intermediate care facility for the mentally retarded beds than the operator receives on the day before that day.

(C) The director shall notify the governor, speaker and minority leader of the house of representatives, and president and minority leader of the senate when the director submits the application for the ICF/MR conversion pilot program under division (B)(1) of this section and the amendment to the state medicaid plan under division (B)(2) of this section. The director is not required to submit the application and the amendment at the same time.

Sec. 5111.881. (A) There is hereby created the ICF/MR conversion advisory council. The council shall consist of all of the following members:

(1) Two members of the house of representatives appointed by the speaker of the house of representatives, each from a different political party;

(2) Two members of the senate appointed by the president of the senate, each from a different political party;

(3) The director of job and family services or the director's designee;

(4) The director of mental retardation and developmental disabilities or the director's designee;

(5) One representative of each of the following organizations, appointed by the organization:

(a) Advocacy and protective services, incorporated;

(b) The arc of Ohio;

(c) The Ohio league for the mentally retarded;

(d) People first of Ohio;

(e) The Ohio association of county boards of mental retardation and developmental disabilities;

(f) The Ohio provider resource association;

(g) The Ohio health care association;

(h) The Ohio legal rights service;

(i) The Ohio developmental disabilities council;

(j) The cerebral palsy association of Ohio.

(B) At least four members appointed to the ICF/MR conversion advisory council, other than the members appointed under division (A)(1) or (2) of this section, shall be either of the following:

(1) A family member of an individual who, at the time of the family member's appointment, is a resident of an intermediate care facility for the mentally retarded;

(2) An individual with mental retardation or a developmental disability.

(C) The speaker of the house of representatives and the president of the senate jointly shall appoint one of the members appointed under division (A)(1) or (2) of this section to serve as chair of the ICF/MR conversion

advisory council.

(D) Members of the ICF/MR conversion advisory council shall receive no compensation for serving on the council.

(E) The ICF/MR conversion advisory council shall do all of the following:

(1) Consult with the director of job and family services before the director submits the application for the ICF/MR conversion pilot program and the amendment to the state medicaid plan under division (B) of section 5111.88 of the Revised Code;

(2) Consult with the administrative agency before the administrative agency makes adjustments to the program under division (F) of section 5111.882 of the Revised Code;

(3) Consult with the director of job and family services when the director adopts the rules for the program;

(4) Consult with the administrative agency when the administrative agency conducts the evaluation of the program and prepares the initial and final reports of the evaluation under section 5111.889 of the Revised Code.

(F) The ICF/MR conversion advisory council shall cease to exist on the issuance of the final report of the evaluation conducted under section 5111.889 of the Revised Code.

Sec. 5111.882. If the United States secretary of health and human services approves the waiver requested under division (B)(1) of section 5111.88 of the Revised Code, the administrative agency shall implement the ICF/MR conversion pilot program for not less than three years as follows:

(A) Permit no more than two hundred individuals to participate in the program at one time;

(B) Select, from among volunteers only, enough intermediate care facilities for the mentally retarded to convert from providing ICF/MR services to providing home and community-based services as necessary to accommodate each individual participating in the program and ensure that the facilities selected for conversion cease, except as provided by section 5111.8811 of the Revised Code, to provide any ICF/MR services once the conversion takes place;

(C) Subject to division (A) of this section, permit individuals who reside in an intermediate care facility for the mentally retarded that converts to providing home and community-based services to choose whether to participate in the program or to transfer to another intermediate care facility for the mentally retarded that is not converting;

(D) Ensure that no individual receiving ICF/MR services on the effective date of this section suffers an interruption in medicaid-covered

services that the individual is eligible to receive;

(E) Collect information as necessary for the evaluation required by section 5111.889 of the Revised Code;

(F) After consulting with the ICF/MR conversion advisory council, make adjustments to the program that the administrative agency and, if the administrative agency is not the department of job and family services, the department agree are both necessary for the program to be implemented more effectively and consistent with the terms of the waiver authorizing the program. No adjustment may be made that expands the size or scope of the program.

Sec. 5111.883. Each individual participating in the ICF/MR conversion pilot program shall receive home and community-based services pursuant to a written individual service plan that shall be created for the individual. The individual service plan shall provide for the individual to receive home and community-based services as necessary to meet the individual's health and welfare needs.

Sec. 5111.884. Each individual participating in the ICF/MR conversion pilot program has the right to choose the qualified and willing provider from which the individual will receive home and community-based services provided under the program.

Sec. 5111.885. The administrative agency shall inform each individual participating in the ICF/MR conversion pilot program of the individual's right to a state hearing under section 5101.35 of the Revised Code regarding a decision or order the administrative agency makes concerning the individual's participation in the program.

Sec. 5111.886. The department of mental retardation and developmental disabilities may not convert any of the intermediate care facilities for the mentally retarded that the department operates to a provider of home and community-based services under the ICF/MR conversion pilot program.

Sec. 5111.887. (A) If the United States secretary of health and human services approves the waiver requested under division (B)(1) of section 5111.88 of the Revised Code, the department of job and family services may do both of the following:

(1) Contract with the department of mental retardation and developmental disabilities under section 5111.91 of the Revised Code to assign the day-to-day administration of the ICF/MR conversion pilot program to the department of mental retardation and developmental disabilities;

(2) Transfer funds to pay for the nonfederal share of the costs of the ICF/MR conversion pilot program to the department of mental retardation

and developmental disabilities.

(B) If the department of job and family services takes both actions authorized by division (A) of this section, the department of mental retardation and developmental disabilities shall be responsible for paying the nonfederal share of the costs of the ICF/MR conversion pilot program.

Sec. 5111.888. The director of job and family services, in consultation with the ICF/MR conversion advisory council, shall adopt rules under section 5111.85 of the Revised Code as necessary to implement the ICF/MR conversion pilot program, including rules establishing both of the following:

(A) The type, amount, duration, and scope of home and community-based services provided under the program;

(B) The amount the program pays for the home and community-based services or the method by which the amount is determined.

Sec. 5111.889. (A) The administrative agency, in consultation with the ICF/MR conversion advisory council, shall conduct an evaluation of the ICF/MR conversion pilot program. All of the following shall be examined as part of the evaluation:

(1) The effectiveness of the home and community-based services provided under the program in meeting the health and welfare needs of the individuals participating in the program as identified in the individuals' written individual service plans;

(2) The satisfaction of the individuals participating in the program with the home and community-based services;

(3) The impact that the conversion from providing ICF/MR services to providing home and community-based services has on the intermediate care facilities for the mentally retarded that convert;

(4) The program's cost effectiveness, including administrative cost effectiveness;

(5) Feedback about the program from the individuals participating in the program, such individuals' families and guardians, county boards of mental retardation and developmental disabilities, and providers of home and community-based services under the program;

(6) Other matters the administrative agency considers appropriate for evaluation.

(B) The administrative agency, in consultation with the ICF/MR conversion advisory council, shall prepare two reports of the evaluation conducted under this section. The initial report shall be finished not sooner than the last day of the ICF/MR conversion pilot program's first year of operation. The final report shall be finished not sooner than the last day of the program's second year of operation. The administrative agency shall

provide a copy of each report to the governor, president and minority leader of the senate, and speaker and minority leader of the house of representatives.

Sec. 5111.8810. The ICF/MR conversion pilot program shall not be implemented statewide unless the general assembly enacts law authorizing the statewide implementation.

Sec. 5111.8811. An intermediate care facility for the mentally retarded that converts from providing ICF/MR services to providing home and community-based services under the ICF/MR conversion pilot program may reconvert to providing ICF/MR services after the program terminates unless either of the following is the case:

(A) The program, following the general assembly's enactment of law authorizing the program's statewide implementation, is implemented statewide;

(B) The facility no longer meets the requirements for certification as an intermediate care facility for the mentally retarded.

Sec. 5111.8812. (A) Subject to division (B) of this section and beginning not later than two and one-half years after the date the ICF/MR conversion pilot program terminates, the department of mental retardation and developmental disabilities shall be responsible for a portion of the nonfederal share of medicaid expenditures for ICF/MR services provided by an intermediate care facility for the mentally retarded that reconverts to providing ICF/MR services under section 5111.8811 of the Revised Code. The portion for which the department shall be responsible shall be the portion that the department and department of job and family services specify in an agreement.

(B) The department of mental retardation and developmental disabilities shall not be responsible for any portion of the nonfederal share of medicaid expenditures for ICF/MR services incurred for any beds of an intermediate care facility for the mentally retarded that are in excess of the number of beds the facility had while participating in the ICF/MR conversion pilot program.

Sec. 5111.89. (A) As used in sections 5111.89 to 5111.893 of the Revised Code:

"Assisted living program" means the medicaid waiver component for which the director of job and family services is authorized by this section to request a medicaid waiver.

"Assisted living services" means the following home and community-based services: personal care, homemaker, chore, attendant care, companion, medication oversight, and therapeutic social and recreational

programming.

"County or district home" means a county or district home operated under Chapter 5155. of the Revised Code.

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

"Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.

(B) The director of job and family services may submit a request to the United States secretary of health and human services under 42 U.S.C. 1396n to obtain a waiver of federal medicaid requirements that would otherwise be violated in the creation and implementation of a program under which assisted living services are provided to not more than one thousand eight hundred individuals who meet the program's eligibility requirements established under section 5111.891 of the Revised Code.

If the secretary approves the medicaid waiver requested under this section and the director of budget and management approves the contract, the department of job and family services shall enter into a contract with the department of aging under section 5111.91 of the Revised Code that provides for the department of aging to administer the assisted living program. The contract shall include an estimate of the program's costs.

The director of job and family services may adopt rules under section 5111.85 of the Revised Code regarding the assisted living program. The director of aging may adopt rules under Chapter 119. of the Revised Code regarding the program that the rules adopted by the director of job and family services authorize the director of aging to adopt.

Sec. 5111.891. To be eligible for the assisted living program, an individual must meet all of the following requirements:

(A) Need an intermediate level of care as determined under rule 5101:3-3-06 of the Administrative Code;

(B) At the time the individual applies for the assisted living program, be one of the following:

(1) A nursing facility resident who is seeking to move to a residential care facility and would remain in a nursing facility for long term care if not for the assisted living program;

(2) A participant of any of the following medicaid waiver components who would move to a nursing facility if not for the assisted living program:

(a) The PASSPORT program created under section 173.40 of the Revised Code;

(b) The medicaid waiver component called the choices program that the department of aging administers;

(c) A medicaid waiver component that the department of job and family services administers.

(C) At the time the individual receives assisted living services under the assisted living program, reside in a residential care facility, including both of the following:

(1) A residential care facility that is owned or operated by a metropolitan housing authority that has a contract with the United States department of housing and urban development to receive an operating subsidy or rental assistance for the residents of the facility;

(2) A county or district home licensed as a residential care facility.

(D) Meet all other eligibility requirements for the assisted living program established in rules adopted under section 5111.85 of the Revised Code.

Sec. 5111.892. A residential care facility providing services covered by the assisted living program to an individual enrolled in the program shall have staff on-site twenty-four hours each day who are able to do all of the following:

(A) Meet the scheduled and unpredicted needs of the individuals enrolled in the assisted living program in a manner that promotes the individuals' dignity and independence;

(B) Provide supervision services for those individuals;

(C) Help keep the individuals safe and secure.

Sec. 5111.893. If the United States secretary of health and human services approves a medicaid waiver authorizing the assisted living program, the director of aging shall contract with a person or government entity to evaluate the program's cost effectiveness. The director shall provide the results of the evaluation to the governor, president and minority leader of the senate, and speaker and minority leader of the house of representatives not later than June 30, 2007.

Sec. 5111.914. (A) As used in this section, "provider" has the same meaning as in section 5111.06 of the Revised Code.

(B) If a state agency that enters into a contract with the department of job and family services under section 5111.91 of the Revised Code identifies that a medicaid overpayment has been made to a provider, the state agency may commence actions to recover the overpayment on behalf of the department.

(C) In recovering an overpayment pursuant to this section, a state agency shall comply with the following procedures:

(1) The state agency shall attempt to recover the overpayment by notifying the provider of the overpayment and requesting voluntary repayment. Not later than five business days after notifying the provider, the state agency shall notify the department in writing of the overpayment. The state agency may negotiate a settlement of the overpayment and notify the department of the settlement. A settlement negotiated by the state agency is not valid and shall not be implemented until the department has given its written approval of the settlement.

(2) If the state agency is unable to obtain voluntary repayment of an overpayment, the agency shall give the provider notice of an opportunity for a hearing in accordance with Chapter 119. of the Revised Code. If the provider timely requests a hearing in accordance with section 119.07 of the Revised Code, the state agency shall conduct the hearing to determine the legal and factual validity of the overpayment. On completion of the hearing, the state agency shall submit its hearing officer's report and recommendation and the complete record of proceedings, including all transcripts, to the director of job and family services for final adjudication. The director may issue a final adjudication order in accordance with Chapter 119. of the Revised Code. The state agency shall pay any attorney's fees imposed under section 119.092 of the Revised Code. The department of job and family services shall pay any attorney's fees imposed under section 2335.39 of the Revised Code.

(D) In any action taken by a state agency under this section that requires the agency to give notice of an opportunity for a hearing in accordance with Chapter 119. of the Revised Code, if the agency gives notice of the opportunity for a hearing but the provider subject to the notice does not request a hearing or timely request a hearing in accordance with section 119.07 of the Revised Code, the agency is not required to hold a hearing. The agency may request that the director of job and family services issue a final adjudication order in accordance with Chapter 119. of the Revised Code.

(E) This section does not preclude the department of job and family services from adjudicating a final fiscal audit under section 5111.06 of the Revised Code, recovering overpayments under section 5111.061 of the Revised Code, or making findings or taking other actions authorized by this chapter.

Sec. 5111.915. (A) The department of job and family services shall enter into an agreement with the department of administrative services for the department of administrative services to contract through competitive selection pursuant to section 125.07 of the Revised Code with a vendor to

perform an assessment of the data collection and data warehouse functions of the medicaid data warehouse system, including the ability to link the data sets of all agencies serving medicaid recipients.

The assessment of the data system shall include functions related to fraud and abuse detection, program management and budgeting, and performance measurement capabilities of all agencies serving medicaid recipients, including the departments of aging, alcohol and drug addiction services, health, job and family services, mental health, and mental retardation and developmental disabilities.

The department of administrative services shall enter into this contract within thirty days after the effective date of this section. The contract shall require the vendor to complete the assessment within ninety days after the effective date of this section.

A qualified vendor with whom the department of administrative services contracts to assess the data system shall also assist the medicaid agencies in the definition of the requirements for an enhanced data system or a new data system and assist the department of administrative services in the preparation of a request for proposal to enhance or develop a data system.

(B) Based on the assessment performed pursuant to division (A) of this section, the department of administrative services shall seek a qualified vendor through competitive selection pursuant to section 125.07 of the Revised Code to develop or enhance a data collection and data warehouse system for the department of job and family services and all agencies serving medicaid recipients.

Within ninety days after the effective date of this section, the department of job and family services shall seek enhanced federal funding for ninety per cent of the funds required to establish or enhance the data system. The department of administrative services shall not award a contract for establishing or enhancing the data system until the department of job and family services receives approval from the secretary of the United States department of health and human services for the ninety per cent federal match.

Sec. ~~5111.88~~ 5111.97. (A) As used in this section and in section 5111.971 of the Revised Code, "nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(B) To the extent funds are available, the director of job and family services may establish the Ohio access success project to help medicaid recipients make the transition from residing in a nursing facility to residing in a community setting. The program may be established as a separate non-medicaid program or integrated into a new or existing program of

medicaid-funded home and community-based services authorized by a waiver approved by the United States department of health and human services. ~~The department~~ The director shall permit any recipient of medicaid-funded nursing facility services to apply for participation in the program, but may limit the number of program participants.If an application is received before the applicant has been a recipient of medicaid-funded nursing facility services for six months, the director shall ensure that an assessment is conducted as soon as practicable to determine whether the applicant is eligible for participation in the program. To the maximum extent possible, the assessment and eligibility determination shall be completed not later than the date that occurs six months after the applicant became a recipient of medicaid-funded nursing facility services.

(C) To be eligible for benefits under the project, a medicaid recipient must satisfy all of the following requirements:

(1) Be a recipient of medicaid-funded nursing facility services, at the time of applying for the benefits;

(2) ~~Have resided continuously in a nursing facility for not less than eighteen months prior to applying to participate in the project;~~

~~(3)~~ Need the level of care provided by nursing facilities;

~~(4)~~ (3) For participation in a non-medicaid program, receive services to remain in the community with a projected cost not exceeding eighty per cent of the average monthly medicaid cost of a medicaid recipient in a nursing facility;

~~(5)~~ (4) For participation in a program established as part of a medicaid-funded home and community-based services waiver program, meet waiver enrollment criteria.

~~(C)~~ (D) If the director establishes the Ohio access success project, the benefits provided under the project may include payment of all of the following:

(1) The first month's rent in a community setting;

(2) Rental deposits;

(3) Utility deposits;

(4) Moving expenses;

(5) Other expenses not covered by the medicaid program that facilitate a medicaid recipient's move from a nursing facility to a community setting.

~~(D)~~ (E) If the project is established as a non-medicaid program, no participant may receive more than two thousand dollars worth of benefits under the project.

~~(E)~~ (F) The director may submit a request to the United States secretary of health and human services pursuant to section 1915 of the "Social

Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396n, as amended, to create a medicaid home and community-based services waiver program to serve individuals who meet the criteria for participation in the Ohio access success project. The director may adopt rules under Chapter 119. of the Revised Code for the administration and operation of the program.

Sec. 5111.971. (A) As used in this section, "long-term medicaid waiver component" means any of the following:

(1) The PASSPORT program created under section 173.40 of the Revised Code;

(2) The medicaid waiver component called the choices program that the department of aging administers;

(3) A medicaid waiver component that the department of job and family services administers.

(B) The director of job and family services shall submit a request to the United States secretary of health and human services for a waiver of federal medicaid requirements that would be otherwise violated in the creation of a pilot program under which not more than two hundred individuals who meet the pilot program's eligibility requirements specified in division (D) of this section receive a spending authorization to pay for the cost of medically necessary health care services that the pilot program covers. The spending authorization shall be in an amount not exceeding seventy per cent of the average cost under the medicaid program for providing nursing facility services to an individual. An individual participating in the pilot program shall also receive necessary support services, including fiscal intermediary and other case management services, that the pilot program covers.

(C) If the United States secretary of health and human services approves the waiver submitted under division (B) of this section, the department of job and family services shall enter into a contract with the department of aging under section 5111.91 of the Revised Code that provides for the department of aging to administer the pilot program that the waiver authorizes.

(D) To be eligible to participate in the pilot program created under division (B) of this section, an individual must meet all of the following requirements:

(1) Need an intermediate level of care as determined under rule 5101:3-3-06 of the Administrative Code;

(2) At the time the individual applies to participate in the pilot program, be one of the following:

(a) A nursing facility resident who is seeking to move to a residential care facility or county or district home and who would remain in a nursing

facility if not for the pilot program;

(b) A participant of any long-term medicaid waiver component who would move to a nursing facility if not for the pilot program.

(3) Meet all other eligibility requirements for the pilot program established in rules adopted under section 5111.85 of the Revised Code.

(E) The director of job and family services may adopt rules under section 5111.85 of the Revised Code as the director considers necessary to implement the pilot program created under division (B) of this section. The director of aging may adopt rules under Chapter 119. of the Revised Code as the director considers necessary for the pilot program's implementation. The rules may establish a list of medicaid-covered services not covered by the pilot program that an individual participating in the pilot program may not receive if the individual also receives medicaid-covered services outside of the pilot program.

Sec. 5111.98. (A) The director of job and family services may do all of the following as necessary for the department of job and family services to fulfill the duties it has, as the single state agency for the medicaid program, under the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" Pub. L. No. 108-173, 117 Stat. 2066:

(1) Adopt rules;

(2) Assign duties to county departments of job and family services;

(3) Make payments to the United States department of health and human services from appropriations made to the department of job and family services for this purpose.

(B) Rules adopted under division (A)(1) of this section shall be adopted as follows:

(1) If the rules concern the department's duties regarding service providers, in accordance with Chapter 119. of the Revised Code;

(2) If the rules concern the department's duties concerning individuals' eligibility for services, in accordance with section 111.15 of the Revised Code;

(3) If the rules concern the department's duties concerning financial and operational matters between the department and county departments of job and family services, in accordance with section 111.15 of the Revised Code as if the rules were internal management rules.

Sec. 5111.99. (A) Whoever violates division (B) of section 5111.26 or division ~~(D)~~(E) of section 5111.31 of the Revised Code shall be fined not less than five hundred dollars nor more than one thousand dollars for the first offense and not less than one thousand dollars nor more than five thousand dollars for each subsequent offense. Fines paid under this section

shall be deposited in the state treasury to the credit of the general revenue fund.

(B) Whoever violates division (D) of section 5111.61 of the Revised Code is guilty of registering a false complaint, a misdemeanor of the first degree.

Sec. 5112.03. (A) The director of job and family services shall adopt, and may amend and rescind, rules in accordance with Chapter 119. of the Revised Code for the purpose of administering sections 5112.01 to 5112.21 of the Revised Code, including rules that do all of the following:

(1) Define as a "disproportionate share hospital" any hospital included under subsection (b) of section 1923 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396r-4(b), as amended, and any other hospital the director determines appropriate;

(2) Prescribe the form for submission of cost reports under section 5112.04 of the Revised Code;

(3) Establish, in accordance with division (A) of section 5112.06 of the Revised Code, the assessment rate or rates to be applied to hospitals under that section;

(4) Establish schedules for hospitals to pay installments on their assessments under section 5112.06 of the Revised Code and for governmental hospitals to pay installments on their intergovernmental transfers under section 5112.07 of the Revised Code;

(5) Establish procedures to notify hospitals of adjustments made under division (B)(2)(b) of section 5112.06 of the Revised Code in the amount of installments on their assessment;

(6) Establish procedures to notify hospitals of adjustments made under division (D) of section 5112.09 of the Revised Code in the total amount of their assessment and to adjust for the remainder of the program year the amount of the installments on the assessments;

(7) Establish, in accordance with section 5112.08 of the Revised Code, the methodology for paying hospitals under that section.

The director shall consult with hospitals when adopting the rules required by divisions (A)(4) and (5) of this section in order to minimize hospitals' cash flow difficulties.

(B) Rules adopted under this section may provide that "total facility costs" excludes costs associated with any of the following:

(1) Recipients of the medical assistance program;

(2) Recipients of financial assistance provided under Chapter 5115. of the Revised Code;

(3) ~~Recipients of medical assistance provided under Chapter 5115. of~~

~~the Revised Code;~~

~~(4)~~ Recipients of the program for medically handicapped children established under section 3701.023 of the Revised Code;

~~(5)~~(4) Recipients of the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended:

~~(6)~~(5) Recipients of Title V of the "Social Security Act";

~~(7)~~(6) Any other category of costs deemed appropriate by the director in accordance with Title XIX of the "Social Security Act" and the rules adopted under that title.

Sec. 5112.08. The director of job and family services shall adopt rules under section 5112.03 of the Revised Code establishing a methodology to pay hospitals that is sufficient to expend all money in the indigent care pool. Under the rules:

(A) The department of job and family services may classify similar hospitals into groups and allocate funds for distribution within each group.

(B) The department shall establish a method of allocating funds to hospitals, taking into consideration the relative amount of indigent care provided by each hospital or group of hospitals. The amount to be allocated shall be based on any combination of the following indicators of indigent care that the director considers appropriate:

(1) Total costs, volume, or proportion of services to recipients of the medical assistance program, including recipients enrolled in health insuring corporations;

(2) Total costs, volume, or proportion of services to low-income patients in addition to recipients of the medical assistance program, which may include recipients of Title V of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, ~~and~~ recipients of disability financial ~~or medical~~ assistance provided under Chapter 5115. of the Revised Code, and recipients of disability medical assistance formerly provided under Chapter 5115. of the Revised Code;

(3) The amount of uncompensated care provided by the hospital or group of hospitals;

(4) Other factors that the director considers to be appropriate indicators of indigent care.

(C) The department shall distribute funds to each hospital or group of hospitals in a manner that first may provide for an additional distribution to individual hospitals that provide a high proportion of indigent care in relation to the total care provided by the hospital or in relation to other hospitals. The department shall establish a formula to distribute the

remainder of the funds. The formula shall be consistent with section 1923 of the "Social Security Act," 42 U.S.C.A. 1396r-4, as amended, shall be based on any combination of the indicators of indigent care listed in division (B) of this section that the director considers appropriate.

(D) The department shall distribute funds to each hospital in installments not later than ten working days after the deadline established in rules for each hospital to pay an installment on its assessment under section 5112.06 of the Revised Code. In the case of a governmental hospital that makes intergovernmental transfers, the department shall pay an installment under this section not later than ten working days after the earlier of that deadline or the deadline established in rules for the governmental hospital to pay an installment on its intergovernmental transfer. If the amount in the hospital care assurance program fund and the hospital care assurance match fund created under section 5112.18 of the Revised Code is insufficient to make the total distributions for which hospitals are eligible to receive in any period, the department shall reduce the amount of each distribution by the percentage by which the amount is insufficient. The department shall distribute to hospitals any amounts not distributed in the period in which they are due as soon as moneys are available in the funds.

Sec. 5112.17. (A) As used in this section:

(1) "Federal poverty guideline" means the official poverty guideline as revised annually by the United States secretary of health and human services in accordance with section 673 of the "Community Service Block Grant Act," 95 Stat. 511 (1981), 42 U.S.C.A. 9902, as amended, for a family size equal to the size of the family of the person whose income is being determined.

(2) "Third-party payer" means any private or public entity or program that may be liable by law or contract to make payment to or on behalf of an individual for health care services. "Third-party payer" does not include a hospital.

(B) Each hospital that receives funds distributed under sections 5112.01 to 5112.21 of the Revised Code shall provide, without charge to the individual, basic, medically necessary hospital-level services to individuals who are residents of this state, are not recipients of the medical assistance program, and whose income is at or below the federal poverty guideline. Recipients of disability financial assistance ~~and recipients of disability medical assistance~~ provided under Chapter 5115. of the Revised Code qualify for services under this section. The director of job and family services shall adopt rules under section 5112.03 of the Revised Code specifying the hospital services to be provided under this section.

(C) Nothing in this section shall be construed to prevent a hospital from requiring an individual to apply for eligibility under the medical assistance program before the hospital processes an application under this section. Hospitals may bill any third-party payer for services rendered under this section. Hospitals may bill the medical assistance program, in accordance with Chapter 5111. of the Revised Code and the rules adopted under that chapter, for services rendered under this section if the individual becomes a recipient of the program. Hospitals may bill individuals for services under this section if all of the following apply:

(1) The hospital has an established post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under this section.

(2) The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following:

(a) Explains that individuals with income at or below the federal poverty guideline are eligible for services without charge;

(b) Specifies the federal poverty guideline for individuals and families of various sizes at the time the bill is sent;

(c) Describes the procedure required by division (C)(1) of this section.

(3) The hospital complies with any additional rules the department adopts under section 5112.03 of the Revised Code.

Notwithstanding division (B) of this section, a hospital providing care to an individual under this section is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

(D) Each hospital shall collect and report to the department, in the form and manner prescribed by the department, information on the number and identity of patients served pursuant to this section.

(E) This section applies beginning May 22, 1992, regardless of whether the department has adopted rules specifying the services to be provided. Nothing in this section alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.

Sec. 5112.30. As used in sections 5112.30 to 5112.39 of the Revised Code~~, "intermediate~~:

(A) "Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code, except that it does not

include any such facility operated by the department of mental retardation and developmental disabilities.

(B) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code.

Sec. 5112.31. The department of job and family services shall do all of the following:

(A) For the purpose of providing home and community-based services for mentally retarded and developmentally disabled persons, annually assess each intermediate care facility for the mentally retarded a franchise permit fee equal to nine dollars and sixty-three cents multiplied by the product of the following:

(1) The number of beds certified under Title XIX of the "Social Security Act" on the first day of May of the calendar year in which the assessment is determined pursuant to division (A) of section 5112.33 of the Revised Code;

(2) The number of days in the fiscal year beginning on the first day of July of the same calendar year.

(B) Beginning July 1, ~~2005~~ 2007, and the first day of each July thereafter, adjust fees determined under division (A) of this section in accordance with the composite inflation factor established in rules adopted under section 5112.39 of the Revised Code.

(C) If the United States secretary of health and human services determines that the franchise permit fee established by sections 5112.30 to 5112.39 of the Revised Code would be an impermissible health care-related tax under section 1903(w) of the "Social Security Act," 42 U.S.C.A. 1396b(w), as amended, ~~the department shall~~ take all necessary actions to cease implementation of those sections in accordance with rules adopted under section 5112.39 of the Revised Code.

Sec. 5112.341. (A) In addition to assessing a penalty pursuant to section 5112.34 of the Revised Code, the department of job and family services may do either of the following if an intermediate care facility for the mentally retarded fails to pay the full amount of a franchise permit fee installment when due:

(1) Withhold an amount equal to the installment and penalty assessed under section 5112.34 of the Revised Code from a medicaid payment due the facility until the facility pays the installment and penalty;

(2) Terminate the facility's medicaid provider agreement.

(B) The department may withhold a medicaid payment under division (A)(1) of this section without providing notice to the intermediate care facility for the mentally retarded and without conducting an adjudication under Chapter 119. of the Revised Code.

Sec. 5115.20. (A) The department of job and family services shall establish a disability advocacy program and each county department of job and family services shall establish a disability advocacy program unit or join with other county departments of job and family services to establish a joint county disability advocacy program unit. Through the program the department and county departments shall cooperate in efforts to assist applicants for and recipients of assistance under the disability financial assistance program ~~and the disability medical assistance program,~~ who might be eligible for supplemental security income benefits under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C.A. 1383, as amended, in applying for those benefits.

As part of their disability advocacy programs, the state department and county departments may enter into contracts for the services of persons and government entities that in the judgment of the department or county department have demonstrated expertise in representing persons seeking supplemental security income benefits. Each contract shall require the person or entity with which a department contracts to assess each person referred to it by the department to determine whether the person appears to be eligible for supplemental security income benefits, and, if the person appears to be eligible, assist the person in applying and represent the person in any proceeding of the social security administration, including any appeal or reconsideration of a denial of benefits. The department or county department shall provide to the person or entity with which it contracts all records in its possession relevant to the application for supplemental security income benefits. The department shall require a county department with relevant records to submit them to the person or entity.

(B) Each applicant for or recipient of disability financial assistance ~~or disability medical assistance~~ who, in the judgment of the department or a county department might be eligible for supplemental security benefits, shall, as a condition of eligibility for assistance, apply for such benefits if directed to do so by the department or county department.

(C) With regard to applicants for and recipients of disability financial assistance ~~or disability medical assistance~~, each county department of job and family services shall do all of the following:

(1) Identify applicants and recipients who might be eligible for supplemental security income benefits;

(2) Assist applicants and recipients in securing documentation of disabling conditions or refer them for such assistance to a person or government entity with which the department or county department has contracted under division (A) of this section;

(3) Inform applicants and recipients of available sources of representation, which may include a person or government entity with which the department or county department has contracted under division (A) of this section, and of their right to represent themselves in reconsiderations and appeals of social security administration decisions that deny them supplemental security income benefits. The county department may require the applicants and recipients, as a condition of eligibility for assistance, to pursue reconsiderations and appeals of social security administration decisions that deny them supplemental security income benefits, and shall assist applicants and recipients as necessary to obtain such benefits or refer them to a person or government entity with which the department or county department has contracted under division (A) of this section.

(4) Require applicants and recipients who, in the judgment of the county department, are or may be aged, blind, or disabled, to apply for medical assistance under Chapter 5111. of the Revised Code, make determinations when appropriate as to eligibility for medical assistance, and refer their applications when necessary to the disability determination unit established in accordance with division (F) of this section for expedited review;

(5) Require each applicant and recipient who in the judgment of the department or the county department might be eligible for supplemental security income benefits, as a condition of eligibility for disability financial assistance ~~or disability medical assistance~~, to execute a written authorization for the secretary of health and human services to withhold benefits due that individual and pay to the director of job and family services or the director's designee an amount sufficient to reimburse the state and county shares of interim assistance furnished to the individual. For the purposes of division (C)(5) of this section, "benefits" and "interim assistance" have the meanings given in Title XVI of the "Social Security Act."

(D) The director of job and family services shall adopt rules in accordance with section 111.15 of the Revised Code for the effective administration of the disability advocacy program. The rules shall include all of the following:

(1) Methods to be used in collecting information from and disseminating it to county departments, including the following:

(a) The number of individuals in the county who are disabled recipients of disability financial assistance ~~or disability medical assistance~~;

(b) The final decision made either by the social security administration or by a court for each application or reconsideration in which an individual was assisted pursuant to this section.

(2) The type and process of training to be provided by the department of

job and family services to the employees of the county department of job and family services who perform duties under this section;

(3) Requirements for the written authorization required by division (C)(5) of this section.

(E) The department shall provide basic and continuing training to employees of the county department of job and family services who perform duties under this section. Training shall include but not be limited to all processes necessary to obtain federal disability benefits, and methods of advocacy.

(F) The department shall establish a disability determination unit and develop guidelines for expediting reviews of applications for medical assistance under Chapter 5111. of the Revised Code for persons who have been referred to the unit under division (C)(4) of this section. The department shall make determinations of eligibility for medical assistance for any such person within the time prescribed by federal regulations.

(G) The department may, under rules the director of job and family services adopts in accordance with section 111.15 of the Revised Code, pay a portion of the federal reimbursement described in division (C)(5) of this section to persons or government entities that assist or represent assistance recipients in reconsiderations and appeals of social security administration decisions denying them supplemental security income benefits.

(H) The director shall conduct investigations to determine whether disability advocacy programs are being administered in compliance with the Revised Code and the rules adopted by the director pursuant to this section.

Sec. 5115.22. (A) If a recipient of disability financial assistance ~~or disability medical assistance~~, or an individual whose income and resources are included in determining the recipient's eligibility for the assistance, becomes possessed of resources or income in excess of the amount allowed to retain eligibility, or if other changes occur that affect the recipient's eligibility or need for assistance, the recipient shall notify the state or county department of job and family services within the time limits specified in rules adopted by the director of job and family services in accordance with section 111.15 of the Revised Code. Failure of a recipient to report possession of excess resources or income or a change affecting eligibility or need within those time limits shall be considered prima-facie evidence of intent to defraud under section 5115.23 of the Revised Code.

(B) As a condition of eligibility for disability financial assistance ~~or disability medical assistance~~, and as a means of preventing or reducing the provision of assistance at public expense, each applicant for or recipient of the assistance shall make reasonable efforts to secure support from persons

responsible for the applicant's or recipient's support, and from other sources, including any federal program designed to provide assistance to individuals with disabilities. The state or county department of job and family services may provide assistance to the applicant or recipient in securing other forms of financial assistance.

Sec. 5115.23. As used in this section, "erroneous payments" means disability financial assistance payments ~~or disability medical assistance payments~~ made to persons who are not entitled to receive them, including payments made as a result of misrepresentation or fraud, and payments made due to an error by the recipient or by the county department of job and family services that made the payment.

The department of job and family services shall adopt rules in accordance with section 111.15 of the Revised Code specifying the circumstances under which action is to be taken under this section to recover erroneous payments. The department, or a county department of job and family services at the request of the department, shall take action to recover erroneous payments in the circumstances specified in the rules. The department or county department may institute a civil action to recover erroneous payments.

Whenever disability financial assistance ~~or disability medical assistance~~ has been furnished to a recipient for whose support another person is responsible, the other person shall, in addition to the liability otherwise imposed, as a consequence of failure to support the recipient, be liable for all assistance furnished the recipient. The value of the assistance so furnished may be recovered in a civil action brought by the county department of job and family services.

Each county department of job and family services shall retain fifty per cent of the erroneous payments it recovers under this section. The department of job and family services shall receive the remaining fifty per cent.

Sec. 5119.61. Any provision in this chapter that refers to a board of alcohol, drug addiction, and mental health services also refers to the community mental health board in an alcohol, drug addiction, and mental health service district that has a community mental health board.

The director of mental health with respect to all facilities and programs established and operated under Chapter 340. of the Revised Code for mentally ill and emotionally disturbed persons, shall do all of the following:

(A) Adopt rules pursuant to Chapter 119. of the Revised Code that may be necessary to carry out the purposes of Chapter 340. and sections 5119.61 to 5119.63 of the Revised Code.

(1) The rules shall include all of the following:

(a) Rules governing a community mental health agency's services under section 340.091 of the Revised Code to an individual referred to the agency under division (C)(2) of section 173.35 of the Revised Code;

(b) For the purpose of division (A)(16) of section 340.03 of the Revised Code, rules governing the duties of mental health agencies and boards of alcohol, drug addiction, and mental health services under section 3722.18 of the Revised Code regarding referrals of individuals with mental illness or severe mental disability to adult care facilities and effective arrangements for ongoing mental health services for the individuals. The rules shall do at least the following:

(i) Provide for agencies and boards to participate fully in the procedures owners and managers of adult care facilities must follow under division (A)(2) of section 3722.18 of the Revised Code;

(ii) Specify the manner in which boards are accountable for ensuring that ongoing mental health services are effectively arranged for individuals with mental illness or severe mental disability who are referred by the board or mental health agency under contract with the board to an adult care facility.

(c) Rules governing a board of alcohol, drug addiction, and mental health services when making a report to the director of health under section 3722.17 of the Revised Code regarding the quality of care and services provided by an adult care facility to a person with mental illness or a severe mental disability.

(2) Rules may be adopted to govern the method of paying a community mental health facility, as defined in section ~~5111.022~~ 5111.023 of the Revised Code, for providing services listed in division (B) of that section. Such rules must be consistent with the contract entered into between the departments of job and family services and mental health under section 5111.91 of the Revised Code and include requirements ensuring appropriate service utilization.

(B) Review and evaluate, and, taking into account the findings and recommendations of the board of alcohol, drug addiction, and mental health services of the district served by the program and the requirements and priorities of the state mental health plan, including the needs of residents of the district now residing in state mental institutions, approve and allocate funds to support community programs, and make recommendations for needed improvements to boards of alcohol, drug addiction, and mental health services;

(C) Withhold state and federal funds for any program, in whole or in

part, from a board of alcohol, drug addiction, and mental health services in the event of failure of that program to comply with Chapter 340. or section 5119.61, 5119.611, 5119.612, or 5119.62 of the Revised Code or rules of the department of mental health. The director shall identify the areas of noncompliance and the action necessary to achieve compliance. The director shall offer technical assistance to the board to achieve compliance. The director shall give the board a reasonable time within which to comply or to present its position that it is in compliance. Before withholding funds, a hearing shall be conducted to determine if there are continuing violations and that either assistance is rejected or the board is unable to achieve compliance. Subsequent to the hearing process, if it is determined that compliance has not been achieved, the director may allocate all or part of the withheld funds to a public or private agency to provide the services not in compliance until the time that there is compliance. The director shall establish rules pursuant to Chapter 119. of the Revised Code to implement this division.

(D) Withhold state or federal funds from a board of alcohol, drug addiction, and mental health services that denies available service on the basis of religion, race, color, creed, sex, national origin, age, disability as defined in section 4112.01 of the Revised Code, developmental disability, or the inability to pay;

(E) Provide consultative services to community mental health agencies with the knowledge and cooperation of the board of alcohol, drug addiction, and mental health services;

(F) Provide to boards of alcohol, drug addiction, and mental health services state or federal funds, in addition to those allocated under section 5119.62 of the Revised Code, for special programs or projects the director considers necessary but for which local funds are not available;

(G) Establish criteria by which a board of alcohol, drug addiction, and mental health services reviews and evaluates the quality, effectiveness, and efficiency of services provided through its community mental health plan. The criteria shall include requirements ensuring appropriate service utilization. The department shall assess a board's evaluation of services and the compliance of each board with this section, Chapter 340. or section 5119.62 of the Revised Code, and other state or federal law and regulations. The department, in cooperation with the board, periodically shall review and evaluate the quality, effectiveness, and efficiency of services provided through each board. The department shall collect information that is necessary to perform these functions.

(H) Develop and operate a community mental health information

system.

Boards of alcohol, drug abuse, and mental health services shall submit information requested by the department in the form and manner prescribed by the department. Information collected by the department shall include, but not be limited to, all of the following:

(1) Information regarding units of services provided in whole or in part under contract with a board, including diagnosis and special needs, demographic information, the number of units of service provided, past treatment, financial status, and service dates in accordance with rules adopted by the department in accordance with Chapter 119. of the Revised Code;

(2) Financial information other than price or price-related data regarding expenditures of boards and community mental health agencies, including units of service provided, budgeted and actual expenses by type, and sources of funds.

Boards shall submit the information specified in division (H)(1) of this section no less frequently than annually for each client, and each time the client's case is opened or closed. The department shall not collect any information for the purpose of identifying by name any person who receives a service through a board of alcohol, drug addiction, and mental health services, except as required by state or federal law to validate appropriate reimbursement. For the purposes of division (H)(1) of this section, the department shall use an identification system that is consistent with applicable nationally recognized standards.

(I) Review each board's community mental health plan submitted pursuant to section 340.03 of the Revised Code and approve or disapprove it in whole or in part. Periodically, in consultation with representatives of boards and after considering the recommendations of the medical director, the director shall issue criteria for determining when a plan is complete, criteria for plan approval or disapproval, and provisions for conditional approval. The factors that the director considers may include, but are not limited to, the following:

(1) The mental health needs of all persons residing within the board's service district, especially severely mentally disabled children, adolescents, and adults;

(2) The demonstrated quality, effectiveness, efficiency, and cultural relevance of the services provided in each service district, the extent to which any services are duplicative of other available services, and whether the services meet the needs identified above;

(3) The adequacy of the board's accounting for the expenditure of funds.

If the director disapproves all or part of any plan, the director shall provide the board an opportunity to present its position. The director shall inform the board of the reasons for the disapproval and of the criteria that must be met before the plan may be approved. The director shall give the board a reasonable time within which to meet the criteria, and shall offer technical assistance to the board to help it meet the criteria.

If the approval of a plan remains in dispute thirty days prior to the conclusion of the fiscal year in which the board's current plan is scheduled to expire, the board or the director may request that the dispute be submitted to a mutually agreed upon third-party mediator with the cost to be shared by the board and the department. The mediator shall issue to the board and the department recommendations for resolution of the dispute. Prior to the conclusion of the fiscal year in which the current plan is scheduled to expire, the director, taking into consideration the recommendations of the mediator, shall make a final determination and approve or disapprove the plan, in whole or in part.

Sec. 5120.09. Under the supervision and control of the director of rehabilitation and correction, the division of business administration shall do all of the following:

(A) Submit the budgets for the several divisions of the department of rehabilitation and correction, as prepared by the respective chiefs of those divisions, to the director. The director, with the assistance of the chief of the division of business administration, shall compile a departmental budget that contains all proposals submitted by the chiefs of the divisions and shall forward the departmental budget to the governor with comments and recommendations that the director considers necessary.

(B) Maintain accounts and records and compile statistics that the director prescribes;

(C) Under the control of the director, coordinate and make the necessary purchases and requisitions for the department and its divisions, except as provided under section 5119.16 of the Revised Code;

(D) Administer within this state federal criminal justice acts that the governor requires the department to administer. In order to improve the criminal justice system of this state, the division of business administration shall apply for, allocate, disburse, and account for grants that are made available pursuant to those federal criminal justice acts and grants that are made available from other federal government sources, state government sources, or private sources. As used in this division, "criminal justice system" and "federal criminal justice acts" have the same meanings as in section ~~181.51~~ 5502.61 of the Revised Code.

(E) Audit the activities of governmental entities, persons as defined in section 1.59 of the Revised Code, and other types of nongovernmental entities that are financed in whole or in part by funds that the department allocates or disburses and that are derived from grants described in division (D) of this section;

(F) Enter into contracts, including contracts with federal, state, or local governmental entities, persons as defined in section 1.59 of the Revised Code, foundations, and other types of nongovernmental entities, that are necessary for the department to carry out its duties and that neither the director nor another section of the Revised Code authorizes another division of the department to enter;

(G) Exercise other powers and perform other duties that the director may assign to the division of business administration.

Sec. 5120.51. (A)(1) If the director of rehabilitation and correction determines that a bill introduced in the general assembly is likely to have a significant impact on the population of, or the cost of operating, any or all state correctional institutions under the administration of the department of rehabilitation and correction, the department shall prepare a population and cost impact statement for the bill, in accordance with division (A)(2) of this section.

(2) A population and cost impact statement required for a bill ~~nshall~~ shall estimate the increase or decrease in the correctional institution population that likely would result if the bill were enacted, shall estimate, in dollars, the amount by which revenues or expenditures likely would increase or decrease if the bill were enacted, and briefly shall explain each of the estimates.

A population and cost impact statement required for a bill initially shall be prepared after the bill is referred to a committee of the general assembly in the house of origination but before the meeting of the committee at which the committee is scheduled to vote on whether to recommend the bill for passage. A copy of the statement shall be distributed to each member of the committee that is considering the bill and to the member of the general assembly who introduced it. If the bill is recommended for passage by the committee, the department shall update the statement before the bill is taken up for final consideration by the house of origination. A copy of the updated statement shall be distributed to each member of that house and to the member of the general assembly who introduced the bill. If the bill is passed by the house of origination and is introduced in the second house, the provisions of this division concerning the preparation, updating, and distribution of the statement in the house of origination also apply in the

second house.

(B) The governor or any member of the general assembly, at any time, may request the department to prepare a population and cost impact statement for any bill introduced in the general assembly. Upon receipt of a request, the department promptly shall prepare a statement that includes the estimates and explanations described in division (A)(2) of this section and present a copy of it to the governor or member who made the request.

(C) In the preparation of a population and cost impact statement required by division (A) or (B) of this section, the department shall use a technologically sophisticated system capable of estimating future state correctional institution populations. The system shall have the capability to adjust its estimates based on actual and proposed changes in sentencing laws and trends, sentence durations, parole rates, crime rates, and any other data that affect state correctional institution populations. The department, in conjunction with the advisory committee appointed under division (E) of this section, shall review and update the data used in the system, not less than once every six months, to improve the accuracy of the system.

(D) At least once every six months, the department shall provide to the correctional institution inspection committee a copy of the estimates of state correctional institution populations obtained through use of the system described in division (C) of this section and a description of the assumptions regarding sentencing laws and trends, sentence durations, parole rates, crime rates, and other relevant data that were made by the department to obtain the estimates. Additionally, a copy of the estimates and a description of the assumptions made to obtain them shall be provided, upon reasonable request, to other legislative staff, including the staff of the legislative service commission ~~and the legislative budget office of the legislative service commission~~, to the office of budget and management, and to the ~~office~~ division of criminal justice services in the department of public safety.

(E) The correctional institution inspection committee shall appoint an advisory committee to review the operation of the system for estimating future state correctional institution populations that is used by the department in the preparation of population cost impact statements pursuant to this section and to join with the department in its reviews and updating of the data used in the system under division (C) of this section. The advisory committee shall be comprised of at least one prosecuting attorney, at least one common pleas court judge, at least one public defender, at least one person who is a member or staff employee of the committee, and at least one representative of the ~~office~~ division of criminal justice services in the department of public safety.

Sec. ~~5121.03~~ 5121.01. As used in ~~this chapter~~ sections 5121.01 to 5121.21 of the Revised Code:

(A) ~~Patient means a person receiving care or treatment in a program or facility that provides services to mentally ill individuals.~~

~~(B) The department means the department of mental health or the department of mental retardation and developmental disabilities, whichever provides care or treatment to the patient.~~

~~(C)~~ "Resident" means a person admitted to an institution or other facility pursuant to Chapter 5123. of the Revised Code who is under observation or receiving habilitation and care ~~in an institution for the mentally retarded~~.

~~(D) State-operated community mental health services means community-based services the department of mental health operates for a board of alcohol, drug addiction, and mental health services pursuant to a community mental health plan approved under division (A)(1)(c) of section 340.03 of the Revised Code.~~

~~(E)~~(B) "Applicable cost" means the rate for support applicable to a ~~patient or~~ resident as specified in this section.

The cost for support of ~~patients in hospitals and~~ residents in institutions under the jurisdiction of ~~the department of mental health or~~ the department of mental retardation and developmental disabilities, and of residents in private facilities or homes whose care or treatment is being paid for by the department ~~of mental retardation and developmental disabilities~~, shall be based on the average per capita cost of the care and treatment of ~~such patients or~~ the residents. The cost of services for ~~mentally ill patients or mentally retarded~~ residents shall be computed using the projected average daily per capita cost at the ~~hospital or~~ institution, or at the discretion of the department ~~under the jurisdiction of which the hospital or institution is operated~~, the subunit thereof in which services are provided. Such costs shall be computed at least annually for the next prospective period using generally accepted governmental accounting principles. The cost of services for ~~mentally retarded~~ residents that are being cared for and maintained in a private facility or home under the supervision of the department ~~of mental retardation and developmental disabilities regional offices~~ and for which a purchase of services contract is being paid to the private facility or home by the department shall not be more than the per diem cost of the contract. The cost of services for a resident receiving pre-admission care, after-care, day-care, or routine consultation and treatment services in a community service unit under the jurisdiction of the department~~,~~ shall be computed on the basis of the average cost of such services at the institution at which they are provided.

~~The cost for support of a patient receiving state-operated community mental health services is an amount determined using guidelines the department of mental health shall issue. The guidelines shall be based on cost-findings and rate-settings applicable to such services.~~

The department shall annually determine the ability to pay of a ~~patient or~~ resident or the ~~patient's or~~ resident's liable relatives and the amount that such person shall pay in accordance with section 5121.04 of the Revised Code.

Collections of support payments shall be made by ~~the department of mental health and~~ the department ~~of mental retardation and developmental disabilities~~ and, subject to meeting prior requirements for payment and crediting of such collections and other available receipts, in accordance with the bond proceedings applicable to obligations issued pursuant to section 154.20 of the Revised Code, such collections and other available receipts designated by ~~the director of the department of mental health and~~ the director of ~~the department of~~ mental retardation and developmental disabilities for deposit in the special accounts, together with insurance contract payments provided for in division (B)(8) of section 5121.04 of the Revised Code, shall be remitted to the treasurer of state for deposit in the state treasury to the credit of ~~the mental health operating fund and~~ the mental retardation operating fund, which ~~are~~ is hereby created, to be used for the general purposes of ~~the department of mental health and~~ the department ~~of mental retardation and developmental disabilities~~. The ~~department of mental health shall make refunds of overpayment of support charges from the mental health operating fund, and the~~ department ~~of mental retardation and developmental disabilities~~ shall make refunds of overpayment of support charges from the mental retardation operating fund.

Sec. ~~5121.01~~ 5121.02. All ~~patients or residents of~~ individuals admitted to a ~~benevolent~~ state institution~~,~~ operated by the department of mental retardation and developmental disabilities under section 5123.03 of the Revised Code shall be maintained at the expense of the state. Their traveling and incidental expenses in conveying them to the state institution shall be paid by the county of commitment. Upon admission, the ~~patients or residents~~ individuals shall be neatly and comfortably clothed. Thereafter, the expense of necessary clothing shall be borne by the responsible relatives or guardian if they are financially able. If not furnished, the state shall bear the expense. Any required traveling expense after admission to the state institution shall be borne by the state if the responsible relatives or guardian are unable to do so.

Sec. ~~5121.02~~ 5121.03. When any person is committed to an institution

under the jurisdiction of ~~the department of mental health or~~ the department of mental retardation and developmental disabilities pursuant to judicial proceedings, the judge ordering such commitment shall:

(A) Make a reliable report on the financial condition of such person and of each of the relatives of the person who are liable for ~~his~~ the person's support, as provided in section 5121.06 of the Revised Code and rules and procedures ~~agreed upon~~ adopted by ~~the director of mental health and~~ the director of mental retardation and developmental disabilities;

(B) Certify to the managing officer of such institution, and the managing officer shall thereupon enter upon ~~his~~ the managing officer's records the name and address of any guardian appointed and of any relative liable for such person's support under section 5121.06 of the Revised Code.

Part I of this act continues in Part II.
*** end of Part I ***